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THE NATIONAL COMMITTEE FOR MENTAL HYGIENE LOOKS AHEAD *

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LAST year Dr. Gregg pointed out very vividly that The National Committee for Mental Hygiene is "The People's Program."¹ You, the National Committee of some 750 leaders, speak, plan, and act for the people of the country, of whom about 5,000 are really active in this field. Your staff is highly appreciative of your backing and participation, but I think we are all agreed that 5,000 in a country of 140 million is not enough. One million, or one for every psychotic person, is a reasonable goal toward which we should aim, and this sets for us a prime task to which the National Committee is devoting itself.

Mental-Hygiene Organization.—The enlistment of one million people requires a consolidation of mental-hygiene effort in the United States, and to this end a committee is currently at work laying out a comprehensive plan. This joint effort will have to include the World Federation for Mental Health and the national, state, and local mental-hygiene organizations. Separate competing programs and financial appeals produce confusion and distrust. The local mental-hygiene society, as yet largely undeveloped, is the channel through which the one million people in the United States must be enlisted and through which they must be given opportunity to work and be used continuously in improving conditions.

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¹ See "The People's Program," by Alan Gregg. MENTAL HYGIENE, Vol. 32, pp. 1-3, January, 1948.

Experiments to this end are under way, and it is anticipated that in the coming year they will be greatly intensified and expanded.

Closely related to functions of the local society and the enlistment of members is the development of the volunteer. Progress is being made in this regard, but we are not pressing this as vigorously as we might, pending the development of local societies. The recruitment and utilization of volunteers are more or less identical with the recruitment of one million citizens to the cause of mental health. Haphazard recruitment and use of volunteers are apt to spoil for the field what may be its greatest asset. The National Council of Jewish Women, The North Atlantic area of the Red Cross, and The American Friends Service, however, warrant special recognition for the thoughtful pioneer work that they have done through the mobilization of volunteers in their local work. Two of our staff have served on the council's advisory committee. Several other organizations are now considering similar work.

Many state mental-hygiene societies during the past year have received assistance from the National Committee on a variety of problems. In addition, we have held conferences of state societies, have published a round robin providing exchange between them, and with one state have participated in joint financing. Basic to our work in this are the long experiences of Mrs. Ginsburg, of our staff, in community organization, and the volunteer help of Mrs. Erna Stenbuck has been of inestimable value. The New York Foundation has given us generous support for this activity.

Our involvement in the international aspects of this four-phased effort was expressed in the immense amount of preparatory work done for the International Congress. Since 1930, the office of the International Committee for Mental Hygiene has been located at our own headquarters. We participated heavily in the preparations for the International Congress held in London this summer and in the formulation of a statement and recommendations by an International Commission which was made in advance of the congress and which defines the immediate international task. We participated in the formation of the World Federation for Mental Health and

are represented on its governing board, which will meet next in Amsterdam on January 5 and semiannually thereafter; and we are serving as the convening organization for the members of the World Federation in the United States. Our Division of World Affairs provides an instrument with which any organization in the United States that becomes a member of the World Federation for Mental Health may affiliate itself and express its full prerogatives as a member. Much of the raising of the budget for the World Federation for Mental Health will devolve on it. The World Federation will be recognized as having consultative status to U. N. E. S. C. O. and possibly the World Health Organization. At the initial meeting of the World Health Organization, we were represented by an observer, Dr. David M. Levy. Members of our council represented us in a regional meeting of U. N. E. S. C. O. on the west coast.

Education of the Public.—The consolidation of mental-hygiene effort, as outlined above, rests upon a foundation of public understanding in which many forces participate. The promotion of such understanding becomes the second great objective of the National Committee. I will not review the continuing activities of the National Committee pointed toward the education of the public, but will choose from the work of the past year those that have been particularly outstanding or new. The demand is beyond our resources.

Dozens of lectures have been given by members of our staff, a well-chosen fraction of those requested. The situation in the Illinois hospitals was presented in an article in *Look Magazine*. Our new book, *Mental Hospitals: A Guide for the Citizen*, by Edith M. Stern, has been purchased by many state governments, one state ordering 1,000 copies. Of another book, *Better Ways of Growing Up*, by J. E. Crawford and Luther E. Woodward, one of our staff is co-author. Another book, *Mental Health in Modern Society*, by Thomas A. C. Rennie and Luther E. Woodward, of our staff, is published by the Commonwealth Fund and results from the work of our Rehabilitation Division. Clifford Beers's *A Mind That Found Itself* has been revised under Dr. Woodward's direction, and a revised edition of *The Mentally Ill in America*, by Albert Deutsch, is shortly to appear.

There have been the annual Lasker Awards, a special award having been given last spring to Mike Gorman, of Oklahoma, for outstanding work done there in public education leading to action. Similar awards will be presented in the coming months to Mr. Albert Deutsch, of the *New York Star*, and Mr. Al Ostrow, of the *San Francisco News*. We have prepared 14 radio recordings for distribution throughout the country under the title, *The Inquiring Parent*, and a commercially sponsored program on this subject is being broadcast at 7:00 P.M., Monday through Friday over WMCA. We have participated in many national conferences held under federal and private auspices. We have now appointed a staff representative to be regularly on hand in Washington to keep us informed of developments there, and to represent us when needed. We participated in the National Health Assembly, and in preparations for the White House Congress on Children and Youth, both under federal auspices.

A most significant development in the enhancement of our capacity for educating the public occurred recently when the Ittleson Family Foundation, in Commemoration of the fiftieth wedding anniversary of the Ittlesons, made available \$10,000 a year for five years for this purpose, another chapter in Mrs. Ittleson's long career of devotion to public mental health. Similarly inspired is a gift in memory of Mrs. Bernard Sachs, to be devoted to the preparation of pamphlet material for public education.

It is significant also that the Council of the American Legion not long ago expressed the intention of launching a nationwide program of mental-hygiene education of the public through The National Committee for Mental Hygiene. Several other national organizations have a similar program now under consideration.

Improved Services to the Mentally Ill.—Citizen organization and public education are both means to an end, not ends in themselves. The National Committee has, therefore, focused its effort on a third objective: improved services for the treatment and prevention of mental illness. Members of our staff have served in an advisory capacity to the Veterans Administration in improving its psychiatric services. With the support of the Commonwealth Fund, we have conducted

an experiment in vocational rehabilitation of the recovered mentally ill, which will eventuate in a monograph on the subject early next year. We have made a nation-wide canvass of the use of shock therapy, the material from which is now being formulated for us in a report by Dr. Granville Jones, of the Williamsburg (Virginia) State Hospital.

Our staff has made studies of clinics and related services in many communities, including Buffalo, Hartford, Austin, Providence, and Topeka, and has given technical help to many states. It has investigated clinics to determine their suitability for the training of personnel. In this it has functioned for the American Association of Psychiatric Clinics for Children, for which our Division on Community Clinics is the secretariat. A canvass of psychiatric clinics in the United States has been made and a directory of some 90 pages published. Dr. Barhash, of our staff, is serving as the secretary general also for the International Association for Child Psychiatry. Fortunately we have been able to strengthen the work of this division through the addition of an assistant director, Miss Mary Bentley. With the severe shortages of staff for clinics, this division is taxed to the utmost. It has currently some fifteen fellows in training for child psychiatry.

Our concern about the adequate administration of the National Mental Health Act is expressed in constant watchfulness of what the states are doing with the funds derived from the federal government. This is the subject of a paper which was presented yesterday afternoon.¹ The inability of our federal bureaus to be very aggressive in dealing with lapses within the states puts upon us the main burden of maintaining high quality. Progress has been made in personnel placement of psychiatric social workers through joint action of the National Committee and the American Association of Psychiatric Social Workers, and plans are being worked out for similar coöperation with the American Psychiatric Association.

We have given aid to a number of government agencies in the setting up of standards of personnel. Several members

¹ See "Some Thoughts Arising from a Preliminary Survey of State Programs," by Abraham Z. Barhash and Mary C. Bentley, pages 40-50 of this issue of MENTAL HYGIENE.

of the staff act as official consultants on mental-hygiene matters to four government agencies—Veterans Administration, United States Public Health Service, Children's Bureau, and Vocational Rehabilitation Bureau—as well as to several national voluntary health and welfare agencies. Five members of our staff are involved in committees of the Group for the Advancement of Psychiatry, which committees are formulating programs and plans for action that will be invaluable to the National Committee.

Two years ago we emphasized the thoroughly unsound basis upon which public psychiatry is founded. Almost daily problems come to our attention to second that viewpoint. We have not had the resources to do what we should like to do in this regard. Our attack has been piecemeal, although I believe we have avoided expending our substance in palliative and patchwork which merely delay the day of reckoning.

Prevention.—The fourth area in the program of the National Committee is the prevention of mental illness. We try to make a distinction between the provision of early treatment, let us say in clinics, after a problem is developed and requires psychiatric services, and the neutralizing of tendencies toward mental ill health and of unhygienic conditions.

Our effort to bring mental-hygiene activities within the routines of the kindergarten recognizes that the public school is a potent force in the prevention of mental ill health. It is aimed at an age group in which tradition is less fixed and a demonstration is more vivid. Our kindergarten project is designed to strengthen the functioning of the teacher, not to relieve him of responsibilities, and so as we go into the fourth year of this project, our special effort is to transfer into teacher education and training on the job what has already been learned and demonstrated. In addition we shall prepare for publication an interpretation of the experiences and conclusions acquired to date in this project.

But even before the child reaches school and in the period in which his attitudes and mental habits are in a still more fluid state, the nurse and the doctor have potentialities for great influence upon the family atmosphere in which he grows. We have participated in a review of the whole field of nursing for Columbia University with this in mind, looking toward

advances in nursing education. Advance copies of a report of this study are on display in our exhibit. We have also worked closely with the public-health-nursing field in order to develop the mental-hygiene potentialities of the public-health nurse as she influences the atmosphere into which a child is born. This is one of the issues of 1948 in our program this afternoon.

Another potent force in the shaping of the child's attitudes and personality is the church. We have a committee, made up of Dr. Sol Ginsberg, Mr. G. Howland Shaw, and Dr. Harry W. Tiebout, now working to enhance the mental-hygiene opportunities of the church. This involves theoretical formulations and the promotion of a psychiatry and a ministry that will take the dynamic forces of both fields into account.

Research.—The research activities of the National Committee are well established. We are now entering the fifteenth year of support of the research in dementia præcox by the Scottish Rite. A book reviewing the work of these years is in course of preparation. This program involves much more than mere allocation of funds by the National Committee, for we have a paid part-time staff member supervising this activity. Again and again the research effort carries over into public education and the organization of services. Through this program we are enabled to enhance scientific knowledge at points at which its lack is holding up progress. We have been enabled to bring together in another book—*Dementia Præcox*, by Dr. Leopold Bellak—a review of the work done in this field over the past ten years.

The same principles hold with respect to our research effort in the field of psychosomatic medicine. It is possible through these researches to focus on areas wherein a lack of knowledge is the bottle neck, while in other areas knowledge already acquired is being ignored in services offered to the mentally ill. Research cannot exist in isolation, for as it reveals new knowledge and the services take full advantage of it, they at the same time reveal needs and leads, create pressures for still more research, and provide the atmosphere in which good research can take place. In return, new knowledge adds pressure for clinical progress.

During the past year, the National Committee has collabo-

rated with Mrs. Albert Lasker in the securing of information about psychiatric research in progress throughout the United States.

You may recall that last year some fundamental changes were made in the administrative set-up of the National Committee. I am pleased to tell you that our board meetings at the present time have a spirit and an interest that fully justifies the changes made. The establishment of a council of fifty-one persons throughout the country, with all the privileges of board members except voting, has made it possible for the National Committee to be represented at several conferences where it would not have been otherwise. Council members attending board meetings from time to time write in their comments on the reports, the minutes of board meetings, and the agenda that are sent to them regularly. We feel that this is a significant step toward the real participation on a nation-wide basis of those who are interested and in a position to exercise leadership. Each year the nominating committee must consider replacements on both board and council and will, I am sure, welcome your suggestions for its consideration.

The National Committee for Mental Hygiene is fortunate in having attracted to its staff a corps of executives, each of high standing in his field. The whole staff is unparalleled in the energy with which they pursue their work and their devotion to it. Every one of them could command higher pay elsewhere. They appreciate your confidence and support.

THE INTERNATIONAL PREPARATORY COMMISSION OF THE LONDON CON- FERENCE ON MENTAL HYGIENE *

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THE International Preparatory Commission of the International Conference on Mental Health, like the various commissions that worked all over the world preparing for the conference, was a new experiment in organization, based upon mental-health principles. Studies on the constitution of committees and congresses and conferences—as well as clinical studies of the individuals who reach the consulting room after having attended too many committees and congresses and conferences—have provided a great deal of data on the ill effects of some of our conventional practices, particularly on the habit by which individuals at conferences represent something—an organization, a country, a profession—and the habit of treating what an individual says as given importance by his status in the world outside the conference, so that a professor outranks an instructor; a division chief, a staff member; the president of a large college, the president of a small one; a president, a dean; the author of ten books, the writer of one. These two organizational habits—running groups and the introduction of distinctions among the group members in terms of irrelevancies imported from outside—were both avoided in the set-up of the commissions that worked before the congress in the different countries, and also in the International Preparatory Commission.

The 300 commissions were set up in this way: Any three people, provided they came from more than one profession or discipline—psychiatry, education, social work, law, anthropology, clinical psychology, housing—might constitute themselves a commission and set to work to prepare a report directed to the agenda of the conference, with the assurance

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that their report would be considered. Never before in the history of conferences and congresses has so informal, so simple, and so fruitful an organizational scheme been tried.

The International Preparatory Commission itself was based on the same scheme. Individuals from different countries and of different statuses, ranging from individuals with international reputations to much less known workers, and from the revered and aged to the young and aspiring, without regard to status, representing no organization, no country, no profession—in the sense that they could compromise or involve others when they spoke—drawing fully on their nationality, their philosophy, and their disciplines when it was a question of what they could give—all worked together for two weeks down in Sussex, England, under the chairmanship of Mr. Lawrence Frank, and succeeded in arriving at a sufficient consensus so that a report could be drafted by the youngest member of the group, and presented to the congress, where it was first discussed in thirty discussion groups and then accepted by acclamation.

I was reminded of another conference that I went to fourteen years ago, of which also Mr. Frank was chairman. At that conference he called together fourteen people from different disciplines in this country—disciplines that had never been spoken of together. He shut us up for a month—not two weeks, but a month—in Hanover, at Dartmouth, and for a month we struggled to talk to one another and to try to get a frame of reference in which a biologist and a child psychologist, anthropologists, sociologists, and psychiatrists could talk together. At the end of a month we went home and we had not even finished the outline of an agreement.

That was fourteen years ago, and we were all Americans, representing about the same spread of disciplines as were represented this summer in Sussex. Fourteen years later it was possible to shut up a more difficult group—more difficult because they came from different countries and hardly spoke one another's languages—representing as wide a spread of interests and capacities, and in two weeks to work out a document—with the same chairman.

This seems to me very important historically. It gives you what is called a control group. So that difference between

Hanover, New Hampshire, in 1934, which was one of the first attempts of its kind in the world, and the workshop at Roffey Park in Sussex, England, in 1948 represents the distance we have advanced in our capacity to talk to one another and to work out some sort of common frame of reference.

I want to say a little more about the organization of the group. In addition to the fact that they did not represent organizations, they were not defending their disciplines, they were not—at least not very often—digging in their heels and saying that sociology says it like this, and so on.

The other interesting thing about this whole set-up was the rate at which we worked—the amount of permissiveness that had to be given to the group to organize itself. That was pretty hard for some of the members to take. Most of them, of course, were professors—fortunately not all of them, but some of them. There was a very wide age span. Our editor, I think, was under thirty, and people who were used to being professors had to consent to being edited by somebody who was under thirty. It was the first conference I had ever attended at which the people younger than I was were even more promising than the people older. There was a wide age span, a very wide status span, and that had to be shaken down. People had to get into the habit of not talking like professors.

So it was necessary to have a rattling-around period, and that is probably one of the most important things that we have discovered recently about the organization of conferences—that a little rattling-around period is very helpful. There is a group at the Massachusetts Institute of Technology that has specialized in how not to begin a meeting—how long a time you need before the meeting begins if it is to be any good. Our group had to be allowed to rattle around and argue about nothing for a while. This always engenders anxiety, and it called for great self-control, on the part both of the chairman and of the participants, not to let ourselves get panicky, especially when we knew that we had to produce a 20,000-word printed document within two weeks. We were allowed to rattle, however, and in the course of the rattling, gradually a form began to emerge.

One of the most interesting experiments was suggested by Dr. Harry Stack Sullivan. Without any warning, in the middle of a session—which looked as if it were not going to be good at all—he suddenly proposed that each person bring in his or her definition of mental health and world citizenship and read it. It sounded absolutely appalling as a suggestion. All of us who had ever fought over definitions knew that it was going to wreck the meeting; at least I was sure it was. But it did not, because the form of the commission was different. If each one of those people had had to make a definition acceptable to his colleagues, his discipline, his organization, to the nominating committee of the next presidential election in his particular organization, and to the political bias inside his own group, of course it would have been appalling. But because they were able to act as thinking, responsible individuals, each person read his own definition and what we found was a vast agreement rather than a vast disparity, because everybody worked to try to communicate with the others instead of trying in one form or another to cover themselves or to protect themselves, for the folks back home. It was striking how well a form of behavior that would have been disrupting in a different organizational set-up worked out in one group.

The next point that was quite extraordinary was the amount of agreement in this fantastically constructed group, with, on the one hand, a gray-haired professor of psychiatry who was just beginning to consider working with the social sciences, and on the other, a young clinical psychologist from England, who had never worked on anything except war-time "combined operations," embodying many disciplines, and who, never having worked with a single discipline, furiously accused us of having a uni-disciplinary approach. Here we were just hanging on by our teeth, keeping psychiatry and sociology and anthropology and clinical psychology together, and he sat and glared and said, "What do you mean by a uni-disciplinary approach? You ought to have a many-facet approach." This was very encouraging. He had grown up in a generation in which he had never known what it was to work in one discipline. He was a product of the war. He represented the future for which the rest of us had worked

so long. Altogether, there was a very high agreement on a number of basic points on which no one would have agreed five years ago.

The general findings that have come out of the Freudian analysis and later developments—the relationship between child and parents and the way it grows up in a society, the sort of learning that the child experiences—were very generally accepted. We did not have to fight any battles about race, about original nature. To be sure, people occasionally insisted that we must mention the fact that some people are born brighter than others. Otherwise, very few theoretical issues were brought out. The fact that institutions develop in the course of the history of a given people and change and are not related to their race or to the fluorine content of the water, and are not tied down to the mystic history of a continent, was very simply accepted.

I did not once in the course of the two weeks have to get up and fight for the concept of culture. Everybody took it so for granted that there would not even have been a pillow fight if I had ever brought the issue up.

We all realized that people in different groups have different habits and bring up their children differently, and that the results are different structures with different mental-hygiene problems on the one hand, and different potentialities on the other.

The main issue, as I see it, in the International Preparatory Commission was primarily the extent to which the mental-hygiene movement is tied down to our own particular Western European cultural forms. That is as an anthropologist would say it. The way it was said by other people was: Is mental hygiene congruent with any culture or, if you took mental hygiene into another society, would it blow it up? In other words, is not mental hygiene a religion in itself? There were people there who thought so and who still do, and who were reasonably convinced that the whole mental-hygiene approach, if properly introduced into whatever cultural or religious system they do not like, would enormously improve it. But at the same time the issue was fought out on both sides. We arrived at a phrasing which said that the practice of mental hygiene was congruent with virtually any civilization. That

is somewhat begging the question of its relationship to a short-term pathological manifestation, like Nazism. It was realized that it was a practice that could be adjusted to China, to India, to different parts of the world, and that it would necessarily be shorn of its particular Western European types of particular value, while still keeping the general essence of mental hygiene—that is, the idea that human beings can learn and that, by applying their intelligence, men can alter either themselves or their institutions in such a way that they can be healthier and better functioning people.

The other pitched battle that raged back and forth in one form or another was an old familiar one. On one side were the clinical psychologists and psychiatrists, who emphasized how much damage could be done in the first four or five years of life, and therefore insisted that the only solution lay in bringing up a new generation. But who is going to bring them up? Distorted parents and teachers? If distorted parents and teachers bring up the children, they are brought up wrong. You have got to fix the parents and teachers first, but how can you unless you begin with them as babies? On the other side were those who looked at the problem of mental health from the point of view of social reforms. They claimed that if we could just fix housing, income tax, the system of economic distribution, relations between labor and management, ownership of land, and the form of nationalism and international relations, we would be able to produce healthy personalities. The only trouble is that even if it were possible to fix all those things, we would have the same people, who would wreck all these institutions again before we had time to produce the new personalities to implement them. That issue recurred over and over again because we had sociologists and political scientists there emphasizing the institutional aspects of change and the clinical scientists emphasizing the importance of the very early years.

It was possible here to take the major insight of the psychiatrist, which is, after all, that adults can change. Psychiatrists work every day, not waiting to grow the right baby for the next president, but dealing with people who are operating now, who are already mothers, who are already chairmen, who are already teachers, who are already loose in

society, and changing them a little. I grant that they do not change them very much, but they do change them a little.

What we kept stressing was that after all psychiatry was the core of this mental-health movement. Sociology, anthropology, law, all these related social disciplines had been brought in, but the insights of psychiatry were what had given it its impetus, and it was what these other disciplines could understand of the findings of psychiatry and relate to their own disciplines that was the peculiar contribution of the mental-hygiene movement. Psychiatrists know something of how adults can change, provided you change them on the basis of what they are to begin with. To translate this into ethnological terms, it means that when you try to change the nature of Chinese, you take into consideration the fact that they are Chinese. When you try to alter Americans, you keep in mind what Americans can do. They can move in certain directions, not in others. They can move a little here and there. You do not start with your newborn baby. You do not start with perfect institution. You start where you are now.

We got our report done almost by the skin of our teeth. The editorial committee was still pasting it together at midnight at the end of the two weeks, and then it was discussed by thirty groups in the conference. I feel that on the whole the conference did what it could do. There were a great many people in America who were disgruntled because it did not do many other things.

What the conference did was to give existence to a multi-disciplinary, cross-national approach to the problems of a better world and a more widely responsible world, to offer a platform on which people of all these disciplines with this common interest can work together, and to give a kind of moral impetus to the formation of the formal body, the World Federation. I think that is all it could do. That is what it was there to do, and I believe it did it.

In this general field of social change, conferences and congresses are the ways in which ideas are born. An idea can live for a long time in the heads of the various members of groups like this. It is not born until a large group of people have come together and said the same things to one another for several days. How many days depends on the size of the

idea. That is what this London conference did. It gave birth, so that you can now say that there is such a world movement. Half the world was not there. Eastern Europe was not there and the Orient was not there. We could only think about them, and we did not think about them very well. In many countries the organization of the national committees is very narrow, and little is known about multi-disciplinary approaches.

Many of the structural features are going to be defective for a long time. Nevertheless, the conference did meet, and did find a common ground of agreement on a great many basic matters that people had not even heard of twenty-five years ago.

If we are to build a world in which people can work together, across political, religious, racial, and professional lines, we need new organizational forms which really embody our new mental-hygiene insights. Too many organizations continue to limp along with the outworn methods of a previous age, with program arrangements inferior to those of a good Boy Scout meeting, and a level of rapport between speaker and audience less intimate than that achieved by the most threatening preacher of a by-gone style of preaching. It was exceedingly encouraging to see that new organizational forms produced a near miracle of mutual understanding and communication at a level that no one who started out on the venture believed possible.

DYNAMIC FORCES IN INTERNATIONAL RELATIONS *

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IT is probably safe to assume that every one in this audience is agreed that we live in the midst of disaster, a disaster that promises to grow worse. I shall, therefore, not labor the point, but mention it only in order to indicate its place as the setting for these comments.

The great forces that prowl across the world to-day are forces for change. The ultimate causes are perhaps lost in obscurity, in half-discovered mysteries like the process of evolution, but many of the more immediate determinants are evident enough. There is pressure for change because the present is intolerable for so many people. Well over half the world is undernourished and millions know starvation. Technologies are disrupting ways of life and making previous modes of livelihood impossible. Cultural patterns are diffusing at unprecedented speed from one society to another, so that positions of leadership and followership are upset, social institutions are disorganized, and people are unable to predict the behavior of one another. Accustomed ways are becoming uncertain ways and old beliefs are tattered before new values are formed to take their place.

Yet all this happens in the face of a spreading realization that things can be better than they are—better, indeed, than they ever have been. Year by year the regions of the world grow smaller in which people are willing to accept as natural or predestined an empty, subsistence existence in which spontaneity is blocked. The kind of vision and determination to achieve improvement that is familiar in the history of this country flourishes now in many other places. Deterioration and reorganization are taking place simultaneously.

What can be done to foster reorganization? Can the

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destructive aspects of change be reduced and a more orderly process be developed? Can we take hold of the human forces that run wild and guide them into constructive channels? When we look around, seeking for a place at which to make a beginning, it becomes evident that one of the great forces both for construction and for destruction is a pattern of human activity that has emerged in comparatively recent years—namely, science, and in particular that branch that is directed at man himself, social science.

When one feels disaster imminent, it is natural for one to look for a remedy, to seek for human forces and human institutions that offer hope. It is equally natural that many of us turn to the familiar home territory of our own profession. Thus, the lawyer is likely to look to control by law, the educator to the spread of enlightened understanding, the statesman to political strategy, the soldier to military force, the philosopher to the insight of a unifying concept, and the religious man to faith and the practice of God's laws.

The social scientist has a similar tendency to turn to what he knows, and he needs to be aware that he is exemplifying a common type of bias. However, even the most conservative and moderate evaluation of his resources and his position reveals some distinctive features. For one thing, social science is new. This means lack of skill, of wisdom, of long-established results, and of many other desirable qualities, but it also means that social science is the one major area of human activity that has not yet been adequately tried. All the other fields of endeavor, from law to religion, have very long histories in which none has so far demonstrated a workable answer to the problem of war. On the contrary, conflict between peoples has grown extensive and destructive beyond anything anticipated in the Dark Ages. Social science may ultimately fail also, but for the present it remains to be given a trial and in this there is some substantial hope.

Another distinctive feature is that social science offers no ready answers, no formulæ for conduct guaranteed to solve the problem. Instead, it offers an instrument and an approach. The instrument is the scientific method and the approach is inquiry, instead of assumption and assertion. The instrument may not as yet be adequate for finding the

answers, but—if the history of science in other fields is any guide—there is a reasonable hope that it can find the way to make the instruments that will ultimately deliver the desired results. Lest even this seem too great a claim, let us add that it is probable that, far from replacing other systems of human thought and activity such as law, education, and so on, social science will be no more than an element necessary for their integration and effectiveness in the service of mankind.

As you will perceive, given current needs, no very dramatic claims are made for social science, but better a dim hope that is real than a bright hope that is a will-o'-the-wisp.

If it is assumed that social science is itself one of the important dynamic factors in international relations, a next step is to consider where and how it can influence the other forces. For this there appear to be at least two different realms or levels of development possible. On the one hand, there can be deeper penetration, more intensive activity, leading to new knowledge regarding the dynamics of human behavior from individual to world society; on the other hand, there can be wider acquaintance with and use of applied social science in the actual operations of human affairs from personal relations to United Nations. It will be my purpose this morning to touch briefly on each of these.

II

The problem of focusing social science on the realignment of other dynamic forces might suggest beginning with an annotated list of the other forces. This would be a lengthy job and not very rewarding, since the forces never appear in nature separated from one another. A more promising approach is to look for problem areas in which the forces run together like cross currents in a sea, causing rips and eddies, and in which, at the same time, particular opportunities for the scientific approach are presented. In many cases this will amount to a complete restatement of issues that are usually presented only in political and economic terms.

For example, let us consider the way in which the members of any given nation perceive another nation. Generally, the people of one country harbor stereotyped images of other countries, starkly simple and exceedingly inaccurate. Yet

these images are the basis upon which people feel for or against other nations, interpret their behavior as villainous or good, judge their actions, and judge what they themselves as a nation should do in relation to the others. It follows, of course, that if the images are false, the resulting line of action can hardly be adequate.

We can explore the causes of these images. This means more than simplistic and partial explanations such as "due to propaganda," "due to Communism," due to international conspiracy, or due to the machinations of some leader or group. It means understanding antecedent events and the current cultural, social, psychological, economic, and other related factors.

I wish to draw your attention here to a resemblance that this kind of problem bears to psychiatry. One of the great contributions of this clinical science is the discovery that while delusions do not make sense in rational terms when tested against reality, they, nevertheless, do make sense as a function in the life of the patient and can be understood in the light of his personality and life history. It is possible to understand some of the causal factors, to appreciate the reasons for tenacity, despite contradictions in reality, and to begin to find ways and means for modification. Cultural anthropology has revealed that numbers of delusions are commonly shared by virtually all members of any given society, that such delusions often have an important function in the lives of the people, and that they can be understood in terms of the past history and present situation—internal and external—of the group. Applied anthropology has further made plain that attempts to modify these cultural delusions demand knowledge regarding the causal factors and determinants. The broadside attack generally proves futile and damaging, just as it does with the individual patient.

The images that people have of nations, the comparison of these images with reality, and the identification of the causal factors are attackable problems that require the combined skills and knowledge of psychiatry, anthropology, psychology, and social psychology (including survey methods and such special procedures as projective tests). The dynamics of society and of the individual are both involved. Until some

headway is made along this line, international relations must always be liable to decisions made on the basis of dangerous fantasies.

This is but one example of many such nodal points in the web of world-wide dynamic forces. It is noteworthy that they present numerous opportunities for the psychiatrist to bring to bear his particular methods of analysis. It is not necessary that he limit himself only to questions that bear directly on psychopathology and the prevention of illness.

III

Turning now to the question of the adequate use of applied social science, it is evident that the complexity and magnitude of the problems together with the need for speed make large-scale organizations necessary. It is also essential that the work be on a continuing basis. Because of the rate at which change is occurring all over the world, single-shot cultural and psychological analyses are liable to be misleading as a basis for action. They are often out of date before they are completed. What is needed is something like the system of weather stations in which observations and analysis go forward continuously and in which there is both immediate reporting of trends and long-range study of basic process.

There might be, for instance, a unit in the federal government that carried out the continuous collection and analysis of information on the causal factors underlying international animosities and international coöperation. These would include the customs, beliefs, and trends of change in other countries, the images they have of us and of one another, the physical, psychological, and social sources of pressure and strain, and the range of possible adjustments. With a view to prevention, an effort could be made to measure the social and psychological strains that can lead to active hostility—that can turn whole nations to the pattern of a crouching cat. On the basis of such work, it would be possible also to spell out in some detail the human-relations planning that must accompany the medical, economic, agricultural, and engineering steps toward relieving world distress; to state the full range of direct and indirect consequences likely to flow from alternative national policies; to appraise, after our policies

have been put into effect, the actual foreign reactions; and, finally, to estimate the cost of peace and survival.

A unit within the government for continuously following changes in the social and psychological factors that influence international relations would be a step in the right direction, but it is not enough. Indeed, it is not even half a loaf, but must be supplemented and counterbalanced by work under other auspices, as, for instance, universities and professional societies. There are a number of reasons for this, such as flexibility and freedom, checking by independent observation, and the prevention of undue secrecy.

The ground plan for a world-wide network of university research is already laid in the "area studies" now going forward. Thus, Harvard and Columbia are concentrating on Russia; Yale, on Southeast Asia; Princeton, on the Near East; Harvard, Yale, and California, on China; Michigan, on Japan; and so on for many others. However, although these developments are encouraging, they still have a long way to go. They lack thus far sufficient gearing to the fact that social change is a continuous process, requiring study by continuous methods. The emphasis is still too much on individual experts rather than on developing teams composed of people from different social-science disciplines capable of doing the enormous, but possible, work necessary to reduce guessing about social and psychological forces.

Of coequal importance with the study of other nations is the necessity for study of our own attitudes and potentials for action in relation to other nations, the changes occurring in these attitudes, and the underlying causes. Even the most superficial observation indicates that our international behavior has major roots not only in what other nations do, but also in events at home. There is need for an institution to tackle this range of problems in a systematic and continuous manner. It should have the size and resources necessary for a thorough and comprehensive job and facilities for disseminating its findings widely both to citizens and to policy makers in the government. Because of the anxieties and interests that would be stirred by such studies, the task would be difficult, but if the mainsprings of our international actions could be brought more clearly into national consciousness, it is hard to imagine a greater service.

A number of other suggestions could be made, but I shall conclude this brief sketch of possibilities with one additional example.

Communities can develop projects for the active utilization of social science in their own affairs and thus give people practice in this way of thinking and acting. They might tackle, from this base, such matters as their mental-hygiene problems, race relations, general apathy to matters of public interest, rumor, delinquency, and many more.

The benefit in this kind of community activity would be more than help in local problems. It would develop people with greater understanding and capacity to act in international affairs. Through working with the local human problems, people can develop familiarity with principles of human relations that have pertinence in understanding what is happening in the larger society. The person who has acquired insight into cause-and-effect relationships in his own community regarding race attitudes, rumor, apathy, social change, and resistance to change, will be far more ready to perceive national and international issues in functional terms and less likely to be satisfied with explanations that do not include anything more than bad men, evil plots, politics, and economics.

In conclusion, let me summarize by saying that after sketching a problem area in which the dynamic forces in international relations are manifest, I have offered some suggestions as to how social science can be channeled in such a way as to operate as a force that can help bring order to the relationships of the other forces and avoid explosive conflict. It may appear that the suggestions are a bit grandiose and cover too much territory. However, it is my feeling that they are no more than the needs of the times require and that if any solution comes, short of experiencing the ultimate disaster, it will come only as the result of extraordinary effort. That is where the hope lies.

The vicious circle, or rather the vicious spiral, is well known in nature. In relations between people, for example, mistrust breeds mistrust and one act can lead to another in ever-progressive deterioration of relations. The same principle, fortunately, applies to constructive action; one reinforces the

other. From many different efforts, which may seem at first to yield little, there is reason to hope that accelerating spirals of progress can emerge that will have far-reaching effects running through the society of the world.

GENERAL PRINCIPLES OF THE FEDERAL PROGRAM FOR MENTAL HYGIENE *

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THE National Mental Health program and the legislation that brought it into being are based upon the fundamental premise that mental health is an integral part of total health and that, therefore, mental hygiene is indispensable in a total public-health program. From a pragmatic standpoint, this means not only that mental hygiene pervades all other public-health programs; it implies also that those measures which have proved successful in the prevention and control of physical illness are applicable to the prevention and control of mental illness.

While there is a general acceptance of this theory in mental-hygiene circles, it has yet to be tested by actual operation on a comprehensive scale. The federal program represents a challenge as well as an opportunity to make that test. It is a challenge that I am confident we can meet successfully if we follow those procedures which have yielded significant gains in other areas of health.

The primary step in such procedure is coöperation among groups and individuals whose interests encompass the many and varying aspects of the mental-health program. Public-health progress is, indeed, a test of the American genius for combining governmental and voluntary responsibility to accomplish important tasks. In this pattern of coöperation, the voluntary agencies have been a vanguard as well as an ally of the official agency. It is usually volunteer groups of citizens who see the need first, who take the pioneering steps in initiating action to meet those needs, and who set in motion the official programs that citizen demand requires.

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This is the reason why the traditional pattern of public health is not one superimposed by government; but, instead, has been a development in which the rank and file of private citizens have played an important part. To keep this balance, voluntary agencies must expand their activities as official programs expand. They must maintain a strong influence in determining what kind and what quality of official services we shall have. This is the essence of democracy and of sound public-health planning.

Correlative with the development of public-health programs through voluntary leadership is the emphasis upon local responsibility for carrying out these programs. This principle of local responsibility is embodied in the National Mental Health Act. As you know, this act makes possible grants-in-aid to foster research, to speed up the training of mental-health personnel, and to strengthen community mental-health services. In each of these fields, autonomy is left with the organizations and localities that receive these grants. Therefore, the program is less a national than a state and local program.

What kind of mental-health program is developed by each state, how effectively it meets the varying needs of the people within that state, depends, in the last analysis, upon the citizens who live there. They will get the facilities and services they want, for they have the final and decisive voice. Their interest and their initiative will set the pattern that is followed, since it would be neither desirable nor practicable to attempt to form a national pattern that would meet the needs of all the different types of community the country over.

The intent of Congress to leave the program in the hands of states and local communities is well expressed in the report of the House Committee on Appropriations, 80th Congress, which states: "The committee is very much interested in the programs and objectives of the Public Health Service and desires to financially implement these programs with every dollar of public money that can be justifiably expended." However, it adds, "Expectations are that in future years states and local communities will shoulder a proportionately larger share of the cost."

We can find justification for such expectations by reviewing

the development of the principle of federal grants-in-aid to states for health activities. Congress launched this form of financial partnership with state and local health agencies in 1936, with an initial appropriation of less than 15 million dollars to the Public Health Service and the Children's Bureau. In 1948, Congress made available for these purposes more than 60 million dollars. This does not include an additional 75 million authorized for hospital construction. In 1935, the year before the federal grant-in-aid program was launched, the appropriations made by the states themselves for their state health departments totaled about 15½ million dollars. By 1948, state appropriations to state health departments had increased to 74½ million dollars. This increase in both state and federal funds for health purposes is of itself impressive evidence that the program has shown its value and workability. It has strengthened state and local programs for maternal and child health, venereal disease, tuberculosis, cancer, and mental hygiene as well as for general health. It has stimulated higher standards, increased the sense of local responsibility, and actually encouraged larger local and state funds for health purposes.

Thus we might say that, measured by the dual gauge of volunteer leadership and local responsibility, the mental-health program is being developed in conformance with traditional public-health procedures. This does not mean that our task in either of these areas is, or ever will be, completed. Despite the excellent work of The National Committee for Mental Hygiene and its affiliate societies, the public has not yet acquired sufficient understanding of the nature of the mental-health problem to provide adequate support and leadership of state and local programs. This offers a rich field of opportunity for professional, voluntary, and official agencies to cooperate in evolving a coordinated plan that will bring essential information to all segments of the population. Even though progress in this area has been slower than we would wish, it is encouraging to note that we are proceeding along a pattern that has repeatedly proved successful in the attack on other health problems.

A more crucial test of the applicability of traditional public-health techniques to mental-health problems comes when we

consider mass control measures. Obviously any public-health program, to be worthy of the name, must provide protection for the population as a whole as well as for the individual. In the older public-health programs, which deal with the control of infectious diseases, mass control measures have been relatively easy to establish. We know the etiology and we know how to prevent most of these diseases, even though our failure to apply this knowledge to the total population results in almost 100,000 deaths annually from preventable causes.

Mass control of the non-infectious diseases, on the other hand—and this applies not only to mental illness, but also to heart disease, cancer, and many other diseases of rising incidence—presents more difficult problems. The etiology of many of them is unknown and consequently preventive measures must necessarily be of a general rather than of a specific nature. Moreover, even these measures call for far more individual participation than do the preventive techniques used to combat infectious diseases. For example, one can immunize against smallpox without significant effect on the personality, whereas consideration of the individual personality is, of necessity, an important factor in measures for preventing mental illness.

Despite such obstacles, however, I believe that mental illnesses and other non-infectious diseases will prove amenable to control on a mass basis. A fair segment of mental disorders—such as those caused by paresis, pellagra, and by various diseases that commonly result in a post-traumatic psychosis—are immediately preventable by attack on their etiology. We know that such attack is best organized through the local health unit. It is my belief that strong local health units, adequately staffed with competent personnel, are also our most promising tool for attacking the more complex problems of mental and emotional disorders as well as other non-infectious diseases.

If the local health unit is concerned, as it should be, with total health, it naturally becomes a focal point for community health planning and for coördinating and integrating the various health resources of the community. Through the instrument of the local health unit, citizens concerned with all aspects of their community's health problems have their

best opportunity to work out effective programs that will benefit all the people. Consequently, I believe that one of the greatest contributions members of this organization can make to the national mental-health program is to join with other professional, health, and civic organizations in working for the establishment and strengthening of local health units.

In this connection, I would like to quote a statement made by your medical director, Dr. Stevenson, at the National Health Assembly last spring. Pointing out that community planning is a function of all health, welfare, education, and like agencies, he said: "Each agency in the community is only a part agency even for its own field." In my opinion, that statement sums up in a few words a fundamental concept that we sometimes tend to forget in our absorption with the pressing and immediate problems in our own special areas of interest.

If we recognize that total health is our mutual and ultimate goal, and if we see our work as a part of the total health program which leads to that goal, the need for a central unit capable of coördinating the several parts becomes obvious. With strong local health units in every community, we will avoid the piecemeal approach which focuses public attention first on one and then on another health hazard, and we will build sustained support for well-planned, well-administered, comprehensive services to deal effectively with the total health problems of the individual and of the community.

HOW THE NATIONAL MENTAL HEALTH ACT WORKS *

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THE National Mental Health Act provides for two separate and distinct types of activity. One type, the operational, is made up of activities that are performed and directly controlled by the Public Health Service. The other type, the assistance activities, have to do with aiding agencies and individuals to perform projects over which the Public Health Service has no direct control.

What are the operational activities over which the Public Health Service has direct control? These are limited to research in the National Institute of Mental Health and to demonstrations. What are the assistance activities that aid agencies and individuals to perform projects over which the Public Health Service has no direct control? These include research grants, training grants, and grants for community services.

It is apparent that the chief purpose of the National Mental Health Act is to assist non-federal agencies in the performance of their activities in the fields of research, prevention, and treatment. It was not intended to have the federal government assume authority and control over such activities. The National Mental Health Act is a mechanism that can be used to initiate or implement preventive and therapeutic services, to further knowledge with regard to emotional disorders, and to increase the number of personnel trained in the fields related to mental health. It is a mechanism that can be used to implement a national mental-health program that is the aggregate of all the programs of all the agencies whose activities relate to the mental health of the people. Such a national mental-health program evolves from and is dependent upon the participation of individuals

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and organizations of all types—local, county, state, national, private, and public.

Operational Activities of the Public Health Service.—To carry out the responsibilities for research under the National Mental Health Act, there is, at the present time, under construction on the grounds of the National Institutes of Health in Bethesda, Maryland, a clinical research center which will include the facilities of the National Institute of Mental Health. Construction has already begun, and it is hopefully anticipated that it will be completed by 1950. In preparation for the opening of this institute, the Public Health Service is supporting a number of research fellows, expecting that from this group it will be possible to obtain some of the staff of the institute.

In addition to the research that will be carried on within the National Institute of Mental Health, there is a need for demonstration projects or field studies. One such project, a clinic, is now in operation in Prince Georges County, Maryland. This first project has as its general objective the study and investigation of the best methods of incorporating mental-health services in a local public-health program. Since 31 of the 53 agencies designated by the states to be the state mental-health authorities are health departments, and since 23 of these health departments had no mental-health program prior to July, 1947, it was considered important to have a demonstration of this particular type.

In addition to study of the best methods of incorporating mental-health services in a local and state public-health program, this project, because it is not committed to supplying all the clinical services demanded by the community, can engage in other areas of activity related to the field of mental health. The usefulness of mental-hygiene clinics as a therapeutic service has been demonstrated both satisfactorily and unsatisfactorily for about twenty years. These mental-hygiene clinics have been overburdened by the number of patients who need treatment. Not only has it been impossible in most instances to satisfy the needs of a community in the matter of treating the sick, but because of lack of time and, in some cases, narrowness of viewpoint, such clinics have been unable to do any significant amount of work of a

really preventive nature. This is true if we regard prevention in its true sense and not in the sense of early treatment of some one already ill.

What can a clinic staff do that is of value in preventing mental illness? Would it be profitable for the staff to devote a considerable proportion of its time to the education of key community groups? One significant activity of this kind is being carried out by the nurse on the clinic staff. This nurse has had training both in public-health nursing and in mental hygiene. Almost all of her time is spent outside the clinic working with public-health nurses and mothers in prenatal and well-baby clinics. This nurse is not supplying therapeutic services for children with emotional problems, but the mothers and nurses are being given the opportunity to acquire an understanding of the emotional needs of children and to learn to handle adequately the everyday problems of the mother-child relationship. One can reasonably speculate that the incorporation of this kind of activity as a part of all prenatal and well-baby services might produce more emotionally healthy children who would never need clinical therapeutic services.

Another type of demonstration project sponsored by the Public Health Service during the past year was institutes for physicians. One such institute was held in Lexington, Kentucky, another in Richmond, Virginia, and a third in Denver, Colorado. These institutes supported by demonstration funds were undertaken with the objective of furnishing knowledge with regard to psychiatry to physicians in general practice. In two instances, the physicians attended a series of lectures and in the other institute, a limited number of physicians both received didactic training and worked with patients. Plans are being made for an institute for a limited number of pediatricians in Minneapolis. These institutes have been sponsored by the state mental-health authority and the state medical association in each location.

Assistance Activities.—As stated above, assistance procedures have to do with activities over which the Public Health Service has no direct control. There are three types of activity for which grants-in-aid may be made—research, training, and community services.

Requests for grants-in-aid to the states for community services originate with the agency designated by each state to be the state mental-health authority. The program is sent to the district office of the United States Public Health Service, where approved action is taken. This action is reviewed by the Mental Hygiene Division headquarters. The non-administrative policies relating to the community-services program are based in large measure on recommendations of the National Advisory Mental Health Council and originate in the community-services committee of that council. The amount of money available to each state is determined by a formula based by law on population, financial need, and the extent of the problem. The state is required to match the federal grant funds with state or local public funds expended for the same purpose. The matching requirements are one dollar of state funds for each two dollars of federal funds.

Requests for research grants originate with institutions, hospitals, or individuals and are sent to the Public Health Service. The project formulated is referred to the Research Committee of the National Advisory Mental Health Council and, after study, this committee makes its recommendation with regard to the project to the council. If the council approves the project, a grant can be made by the service. The method of procedure on training grants, both for graduate and undergraduate grants and for stipends, is similar to that for research grants, requests being referred to the training committee of the advisory council.

The Public Health Service has consultative personnel on duty in most of the district offices to assist the states. These personnel are available to advise with regard to the formulation of programs, their content, and other problems. It is also the responsibility of the consultants to conduct program reviews to ascertain the conformance of the program with the plans on which grants were based, and the progress made in carrying out such plans.

Research Grants.—The tabulation below summarizes the information with regard to grants for research and for research fellowships for the period July, 1947, through September, 1948. The difference between the total amount

granted in fiscal 1949 and the amount available will be used for grants approved during the balance of the fiscal year, which ends June 30, 1949.

GRANTS FOR RESEARCH AND FOR FELLOWSHIPS, 1948 AND 1949

Year	Grants for research		Grants for fellowships		Total amount
		Amount		Amount	
1948.....	38	\$373,664	20	\$64,822	\$438,486
1949.....	29	410,443	7	26,300	436,743*

* Total available for 1949 is \$570,000.

Training Grants.—The data with regard to grants for training and stipends made during the fiscal years 1948 and 1949 are summarized in the two tabulations below. These grants were for graduate training programs in psychiatry, psychiatric social work, clinical psychology, and psychiatric nursing.

GRANTS FOR TRAINING AND FOR STIPENDS—1948

	Grants for training		Grants for stipends		Total amount
		Amount		Amount	
Psychiatry	22	\$333,450	81	\$187,010	\$520,460
Clinical psychology ..	19	145,600	40	64,833	210,433
Psychiatric social work	11	139,595	50	72,000	211,595
Psychiatric nursing..	10	126,224	59	109,600	235,824
Totals	62	\$744,869	230	\$433,443	\$1,178,312

GRANTS FOR TRAINING AND FOR STIPENDS—1949

	Grants for training		Grants for stipends		Total amount
		Amount		Amount	
Psychiatry	24	\$408,859	72	\$234,650	\$643,509
Clinical psychology ..	28	230,710	55	95,432	326,142
Psychiatric social work	18	204,280	62	111,000	315,280
Psychiatric nursing ..	16	158,605	82	144,961	303,566
Totals	86	\$1,002,454	271	\$586,043	\$1,588,497

Beginning July, 1949, funds will be available for grants to medical schools for undergraduate training programs in psychiatry. Applications have been received and will be acted upon by the training committee and the council in December. The last Congress approved contract authorization for this purpose in order to provide continuity of the programs and assurance of continued support.

Grants to States.—In accordance with the provisions of the National Mental Health Act, each state was requested to designate one agency that would be responsible for and have control of the state mental-health program. This agency is called the state mental-health authority. The Public Health Service deals with this designated agency on all matters pertaining to the state program. It is this agency that has the responsibility for formulating and carrying out the program within the state. In 31 states¹ this agency is the health department; in seven, it is the department of mental hygiene; in another seven, the department of welfare; in two, the department of health and welfare; and in six, various other departments.

Grants-in-aid funds became available in July, 1947, and during the first year of operation, 46 states formulated programs and received grants.² It is particularly significant that of these 46 states, 24 had had no program in the designated agency prior to July 1947. This means that the mental-health program had received no official assistance, but had been recognized and when funds became available, action was taken.

The activities included in the state programs that were proposed during fiscal year 1948 group themselves into five categories—central administrative activities, professional services, clinic services, preventive and educational services, and training.

Central administrative activities:

- Making a roster of mental-health facilities
- Registering the mentally handicapped
- Inspecting mental-health facilities
- Conducting special studies

Professional services:

- Psychiatric
- Psychological
- Psychiatric social work
- Psychiatric nursing

Clinic services:

- All purpose
- For children only
- For adults only

¹ Including the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands.

² Five states (Alabama, Indiana, Missouri, Pennsylvania, and Wyoming) and two of the territories (Puerto Rico and the Virgin Islands) did not submit plans.

Educational services:

For the general public

For the professional personnel

Training:

Providing stipends for students in training

The activity represented in the greatest number of programs was training, which appeared in 40 of the plans submitted. Next came educational services, first for professional personnel, then for the general public; conducting special studies; professional services in psychiatry; all-purpose clinic services; making a roster of mental-health facilities; and psychiatric-social-work services. All of these were included in 30 or more of the plans. The activities least often represented were psychiatric-nursing services and the inspection of mental-health facilities, each of which appeared in fewer than 20 of the plans.

Three million dollars were available for state grants-in-aid in the fiscal year 1948, and of this amount, plans were approved that carried budgets totaling \$2,133,360. Of the amounts of money budgeted for the various categories of activities, the largest amount—61 per cent—was for clinic services, 35 per cent going to clinics financially supported and operated by state mental-health authorities, and 26 per cent to clinics financially supported, but not operated by state mental-health authorities. Sixteen per cent went for professional services. The money budgeted for training—11 per cent—was for the financial support of trainees who would return to work in the state mental-health programs. The amount budgeted for preventive and educational activities—8 per cent of the total—was very small. Even if one recognizes that part of the function of the staff of clinic and other professional personnel is in this field, it appears that too little attention is being paid to these activities. One per cent was for special studies. The remaining 3 per cent went for general administrative activities.

One type of assistance given to the states is in the form of surveys of mental-health facilities in the states. The paucity of this type of information is surprising. Each state survey requires from one week to a month and the Mental Hygiene Division of the United States Public Health Service has one medical officer who devoted his entire time

to this activity. Twenty-nine of the states have been surveyed,¹ leaving 23 states and territories still to receive this service.

Quarterly expenditure reports of the states indicate that there was considerable delay in initiating programs during the first year of operation. Only 19 states utilized funds during the first quarter of the year, expenditures amounting to only \$39,954. Many states were unable to formulate programs until later in the year, and some seven states and territories were unable to do so at any time. But as the year went on, more and more states utilized the funds budgeted. In the second quarter, expenditures came to \$115,529; in the third quarter, to \$260,718; and in the fourth, to \$748,016. At the end of the year, a total of \$1,164,217 had been expended and obligated.

A number of factors limited the amount of money that could be used in community-service programs during this first year. There was the delay incident to formulating and initiating new programs; there was the difficulty of obtaining trained personnel because of shortages and low salaries; there was an inability to utilize funds because of the necessity for having employees under a merit system; in some states, legislation was required to permit the state mental-health authority to re-allocate funds to other agencies; there were delays in designating the responsible state agencies.

Even though all of these things were relatively unmodifiable, one is impressed by the opportunities that were not fully utilized. There are strong indications that the activities of existing clinics in some states could have been increased if funds had been re-allocated by the state mental-health authorities to these clinics. Additional trainees could have been supported who would have had their training completed by last July or next. In some instances, there was a tendency to limit the use of funds to one agency instead of bringing into the program other interested groups. More aggressive

¹ These are Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Texas, Virginia, Washington, Wisconsin. Special surveys have also been made of the District of Columbia and the Pittsburgh and Allegheny County area in Pennsylvania.

action by individuals or groups in some states would have resulted in the provision of additional clinical services for people in need of treatment. There are a number of states whose programs would be more satisfactory if an advisory board would assist the state mental-health authority in the formulation of plans, and would support and help activate these plans.

Some encouraging results were obtained. Mental-health programs were initiated in the responsible agencies in 24 states. Existing programs were expanded in a small or large degree in an additional 22 states. One index of progress was the establishment or the expansion of mental-health clinics. One hundred and three clinics in 34 states were either established or expanded. Thirty-six clinics were established, 16 on a full-time and 20 on a part-time basis. Sixty-seven clinics expanded their activities. Thirty-six of these were full-time clinics and 31 part-time. Another index of increased activity is the increase in the number of full-time personnel employed by the agencies designated as the state mental-health authorities. In 32 states for which information is currently available, the number increased from 169 in June, 1947, to 269 in June, 1948. These figures do not include full-time personnel employed in activities given financial support, but not operated by the state mental-health authority, nor does it include any part-time personnel. Assumption of responsibility by the states is evidenced by such occurrences as the recent biennial appropriations of Mississippi and Montana of \$50,000 each for mental-health activities.

In conclusion, let me say that the National Mental Health Act was conceived by people who had a deep appreciation of the emotional difficulties of their fellow men. It came into being because it had the widespread support of people who wanted to see some action taken that would help resolve some of our problems. A number of acute pains are associated with the early growth and development of the program. There are some differences of opinions among those greatly interested as to how rigid or permissive should be the control of this infant. Some ask why rigid federal control of assistance activities is not extended to state and local activities.

Others are reluctant to accept assistance because of a fear of control. There are those who feel that growth has been too slow; a few who think that a diagnosis of hyperpituitarism is indicated.

From the information presented, it becomes apparent that the National Mental Health Act works and will continue to work only through the close coöperation and support of many agencies and individuals.

SOME THOUGHTS ARISING FROM A PRELIMINARY SURVEY OF STATE PROGRAMS *

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LAST summer, at a staff conference of The National Committee for Mental Hygiene, some of us were exchanging bits of information as to how National Mental Health money was being spent in the various states. We all agreed that this was a matter of vital importance to the mental-health future of the country, but when we got through, we had to admit that the information we had was pretty meager. It was at this point that Dr. Stevenson suggested that it would be very useful for some one to make a study of these expenditures, and to report upon them to an interested group. It had to be some one who had no official connection, either with the federal government or with the states involved. We all accepted this with such enthusiasm that when Dr. Stevenson suggested further that the Division on Community Clinics might be the appropriate agency to make this study, we found ourselves so far out on a limb that we could not crawl back gracefully. We had some idea even then that we were undertaking something that was quite beyond our resources in staff and time, but this became painfully more and more clear to us as we progressed with the work.

What we have been able to produce certainly cannot masquerade as an authoritative survey of the situation that we set out to study. We have, however, been able to take a sampling of the kind that gives us, we believe, a fairly good notion of general trends, some of which we found favorable and some unfavorable in the light of our own biases. We

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have become acquainted with a variety of local approaches to the solution of nation-wide problems, and here and there we have stumbled across very stimulating ideas and even across some encouragingly successful implementations of these ideas. We should like to use our time here to-day to reflect a little on what we saw, particularly on those aspects of it which might have practical implications.

In order to get the information upon which this report is based, we wrote to the appropriate staff members of the United States Public Health Service, both in Washington and in some of the regional offices. We wrote for information to all the state health authorities, and in 38 states we were able to make contacts with certain individuals and groups (such as mental-hygiene societies) who have an interest in mental health and who might reasonably be supposed to be well informed as to their state programs. Some of the information we needed we were able to pick up in the course of field trips and clinic contacts, which are part of the division's regular activity. In some instances, we were able to arrange for special field trips in order to fill in a few of the more obvious defects that must arise in any survey based so largely upon information gathered by mail. If we have any apology at all about this paper, it is because it is not backed up by as many such personal visits as we should like to have made.

In gathering this information, we were struck first of all by the great number of instances in which individuals who had a legitimate interest in the matter had been kept completely in the dark as to how National Mental Health Funds were being expended in their own states. With a few exceptions, we ourselves did not encounter any obstructive reticence on the part of state mental-health authorities. That was because we were working out of a national organization, backed by the prestige of that organization, and possibly also by the implied blessing of the United States Public Health Service (although we did nothing to lay claim to that blessing). We were first amazed and then troubled by the number of people who wrote that they had tried long and unsuccessfully to get exactly that information for which we asked. Some of them even ended up with the suggestion that if we

could get the information where they had been unsuccessful, they would appreciate our transmitting it to them. We wish to stress that these were people whose professional status or organizational affiliations gave them a perfect right to be informed as to how their states were conducting their mental-health programs, and yet they have been completely blocked in their efforts at getting the desired information.

Now it is not our wish to digress into the field of political philosophy, but we believe that such official reticence can have a very detrimental effect upon state programs, and that makes it an appropriate matter for our consideration here. Aside from the fact that interested citizens have a perfect right to know how public monies are being spent, the controls exercised by such citizen interest offer one of the best assurances of a sound program. We believe that no amount and no kind of government supervision can take the place of a healthy assumption of responsibility by citizens and citizen groups for the effective functioning of their state and federal agencies.

This is particularly true in the operation of the National Mental Health Act, since the Public Health Service has had to be careful not to exercise so much supervisory control that it might be said it was interfering with local prerogative. We, therefore, find it unfortunate that so many state mental-health authorities have surrounded themselves with the air and the method of secret diplomacy. We feel that in doing so they have discouraged that kind of citizen participation without which no broad mental-health program, state or federal, can ever achieve its ultimate goals.

The authors realize that in selecting individual items for discussion from the mass of material that has been gathered, we run the risk of neglecting and obscuring some of the more important general impressions. In order to minimize this risk, we shall try to sum up a few of these at this point early in the paper. For instance, it is definitely our impression that the broad purposes of the National Mental Health Act are being achieved well enough to justify continuing enthusiastic support for the entire program. This does not constitute a blanket approval of the program, for you will see later that we take issue with some of the things that have

been done. It does, however, express our view that when we try to balance successes against failures, we come out with the general impression that the former far outweigh the latter.

Perhaps the greatest over-all gain that has been accomplished since the initiation of the program is that the helpless and lethargic attitude toward the improvement of mental health has been largely dissipated. Several years ago one met just as many people who knew what needed to be done toward the improvement of mental health, but there were many fewer than there are to-day who were ready to get up and get going. It is hard to overestimate the beneficial effect of the encouragement that the National Mental Health Act has given to a group of workers who a few years ago were overwhelmed by the prospect of insurmountable problems.

This change in attitude is an extremely important one. Accomplishments that at one time were considered as unrealistic fantasies now move into the realm of realistic possibilities. This gives a tremendous impetus to the efforts of the workers involved and makes their work more effective, altogether aside from the financial assistance that it gives them. One of the fears that we often heard expressed prior to the operation of the act was that the assumption of federal responsibility for mental health would result in a dropping off of state and local responsibility. It was our belief that if this really came to pass, the net effect of the federal program would certainly not be beneficial; therefore, we gave particular attention to this item. We find that the operation of the National Mental Health Act thus far has justified very few of these fears. Here and there one finds some tendency to get financial relief for local agencies by using federal funds for rebudgeting purposes, without actually adding to the total programs. Where this happens, the intent of the act is not being carried out. Fortunately, however, these instances are quite rare. By and large, states and communities have been encouraged by federal assistance to assume their own burden, whereas prior to the assistance that burden was much too heavy for them to attempt.

We believe we have made it sufficiently clear that we consider the operation of the National Mental Health Act

extremely important and necessary. As a matter of fact, the only justification for this entire paper is that we consider it so important and so necessary that every possible effort should be made to free it of any discernible flaws in its operation. It is altogether in that spirit that we shall discuss those flaws which we think we have found.

One of the major difficulties faced by the mental-health field is that chronic poverty has left it ill-prepared to spend the money it has suddenly acquired under the National Mental Health Act. Very justifiably, the United States Public Health Service has stressed the necessity of spending a major portion of this money for the expansion of out-patient clinical facilities, the area in which our shortage has been most severe. It is understandable that this expansion has been carried out with an abundance of enthusiasm that has too often clouded good judgment. Too many people are forgetting that, even given the money, there are still many obstacles to the setting up of adequate mental-health services.

Certainly the most immediate of these, and the one that will give us the most trouble for many years, is the shortage of properly qualified staff, but we shall take that up later. It would take us too far afield to discuss the many items of community preparation necessary for the establishment of clinical psychiatric services. We refer to such items as community education, proper liaison with other health and welfare services, provision for continued financial support, and so on. But we wish to point out that in too many instances these and similar items of preparation are being completely neglected in the scramble to get on the band wagon of clinic expansion. We don't know all the reasons for the rush, but we suspect that one of them is the desire of communities to get as much money as possible before the source dries up.

The net result of this rush is twofold. Not only are ill-qualified services being set up, but the total development of the program becomes haphazard and unplanned, since each new venture is accepted not because it fits into the total plan, but because it happens to be pushed first or hardest. Of course this haphazardness is not universal. There were some states that anticipated adding community clinics year by year in a very planful fashion. One state provided for

the eventual assumption of financial responsibility by local communities over a period of about ten years. Two other states planned the expansion of their programs on a regional basis, both for clinics and for other projects, the rate of expansion being geared chiefly to the availability of competent staff.

We found that very often state and local authorities sought to justify the ill-prepared expansion of clinical facilities by arguing that they had the money to spend and if they did not spend it, would lose the appropriation in the future. We take issue with this view on two counts: First, we believe that all the money that is now available for mental-health programs (and all that can possibly be appropriated in the foreseeable future) can be effectively spent, if we plan carefully and give proper attention to what are the needs and the possibilities at each stage of program development. Second, it is our opinion that where a community or a state is unable to find good and effective use for its money, it stands in a much stronger position for requesting a new appropriation if it can show that it wasted nothing of the old one, but rather preserved those sums which it was unprepared to spend well.

While we are on the subject of how expenditures are accounted for, we should like to say something about the relationship between the description of a program and its realities. One of the undesirable by-products of incomplete education is that people learn terminology much more quickly than they learn effectiveness. Many more people can describe the best things to do than are able to do them. As a result, so many people know the right answers that the description of mental-health programs take on a sameness that altogether belies the vast differences one finds in the actualities of operation. We do not believe that this is due to dishonest intent. Some of it is due to the very natural disinclination of people to be harsh in their judgment of themselves. Much more is due to the fact that those who write program descriptions think it expedient to stress only the favorable aspects of their work, lest mention of the unfavorable call forth criticism or jeopardize appropriations. We believe that such fears are both unwarranted and unwise.

Their result is that communities and clinical services live in a fool's paradise until the day comes when the lid blows off. More realistic descriptions and more critical self-evaluations would pave the way for gradual, progressive improvements, and would help avoid the recurring crises that are all too frequent in our field.

We now come to the consideration of what is always the major obstacle to the development of a mental-health program—*i.e.*, the shortage of qualified staff. That staff shortages are severe and crippling has become so axiomatic that it is hardly necessary to document that fact here. However, it is necessary to point out some of the various ways in which this problem is being solved in some places—and evaded in others. This merits particular consideration because, in large measure, the effectiveness of the nation's mental-health program will depend upon how well we can deal with the difficulties created by staff shortages and staff inadequacies.

We now have a state of affairs in which a great number of workers in the broad field of mental health are unprepared by training and experience for the performance of the specific tasks that fall to their lot. Many of the varied functions that need to be performed in a mental-health program to-day call for different degrees and different kinds of preparation. Probably the most serious errors that are being made in the staffing of mental-health services result from overlooking this need for specificity of training. We find all over the country examples of second-rate staffing with individuals who could do a first-rate job if they were either used in the right places or retrained for the places in which there is need for them.

For example, it is our belief, even if it is somewhat sacrilegious, that the term "psychiatrist" has nothing magic about it. Because a man fits the description of "psychiatrist," or even "trained psychiatrist," does not mean that he can successfully undertake any task in the psychiatric field. When he is asked to perform tasks for which his only preparation is the prestige and the halo of the term "psychiatrist," then it must be said that he becomes an inadequate staff member. Much too often psychiatrists whose entire background has been in mental hospitals are called upon,

without additional training, to undertake out-patient treatment, the direction of community clinics, work with children, and consultation with social agencies—for none of which they have any preparation.

For some reason fewer demands for specific training have been made upon psychiatrists than upon other workers in the field. We see numerous communities that would not think of employing a psychiatric social worker unless he were properly trained in an approved school. Yet these same communities will and do employ unqualified psychiatrists to direct the total program in which these trained social workers are employed. This results in untenable professional relationships, in the deterioration of services, and in excessive staff turnover.

That improper staffing is not the only solution to existing personnel shortages is proven by the examples of an increasing number of states which are unwilling to hobble their programs in this way and are, instead, taking measures that are more effective and more promising. The state mental-health authorities who approach this problem most thoughtfully and farsightedly are putting increasingly more of their effort into training the kind of personnel they need, and into expanding their training resources. One state had the experience of starting two similar clinics at about the same time, one directed by a psychiatrist with good child-guidance training, and one by a psychiatrist with no specific training of this kind. The resulting contrast in the operation of these two clinics has led this state to the decision to set aside funds for the child-guidance training of several of their younger psychiatrists before opening any more new clinics.

One state is spending a very large portion of its allotment in the expansion and strengthening of several of its best clinical facilities which promise in time to become training centers for the psychiatric personnel which that state needs so badly. One community clinic, supported in part by federal funds, obtained the services of a psychiatrist of such prominence that no one could think of questioning his adequacy in any phase of psychiatric work. However, he himself had the insight to question his preparedness for certain aspects of his new job, and the courage to insist that he be given ample

training opportunity to remove the deficiencies. (In this case it involved six months' paid leave of absence for training at one of the leading centers.) As a result this clinic now has a very competent director at a cost that is insignificant compared to the huge sums that other clinics have wasted upon inadequate personnel. In the same state, for instance, we find a contrasting example of a child-guidance clinic that started with a well-qualified psychiatrist, but one who had no background in children's work. The fond hope that he would "pick up" the necessary competence as he went along has failed to materialize, so that now, after a year, it is recognized that he will be unable to do the job for which he was hired. Yet he is perfectly competent in other psychiatric work, he made no false claims when he was engaged, and he has done nothing for which he could be discharged—which leaves the community in a very difficult dilemma.

Time does not allow us to quote the dozens of examples we can find of both good and bad solutions of the problem of staff shortage, but we find that the lessons are unfailingly the same—namely, that delays are never as damaging as bad starts; and that a little psychiatry (when the term "little" is qualitative as well as quantitative) is much worse than no psychiatry at all. We ought to point out here that a great deal of confusion has arisen in the country as to the position of the United States Public Health Service on this point. Many individuals have indicated to us their belief that that position is based rather upon the thesis that "a little psychiatry is better than none at all." Therefore, these people felt that they were acting in compliance with the wishes of the United States Public Health Service when they started clinical and other programs before they had competent staff. Since this is not what we believe to be its position, it would be very helpful for the Public Health Service to formulate its views in this matter and to state these to the field in writing in a way that will leave no room for misinterpretation.

Probably because we ourselves feel most at home in commenting upon clinical services, we have devoted a major portion of our paper to this aspect of the National Mental Health Act. However, we wish to avoid any misunderstanding by stressing that, neither by the terms of the act nor in our

own view, should the development of mental-health programs be too largely restricted to the expansion of clinical facilities. Broad health, welfare, and educational services should contribute much more toward the development of sound mental health than can possibly be achieved by the psychiatric specialty group alone. The country at large will never be well-served in this field until use can be made of the tremendous mental-health potential in the work of such people as general practitioners, pediatricians, nurses, school personnel, and many others. We are, therefore, altogether in accord with the emphasis which the Public Health Service has laid upon the teaching of psychiatric insights and judgment to the members of these groups.

Unfortunately, however, we find in the field a great deal of misconception about and misuse of this highly desirable training program. Too often general practitioners are being trained in psychiatry to make them not better general practitioners, but rather substitute second-rate psychiatrists. Similarly, teachers are taught to become substitute psychologists, nurses to become substitute social workers, and so on up and down the line, until no one retains any sense of importance in his own work, and every one thinks of training as a means of climbing upward in a mythical hierarchy.

Even if it were possible to achieve a surplus of highly skilled psychiatrists, psychologists, and social workers, the major portion of the broad mental-health job would still have to be done by members of other disciplines. It, therefore, defeats our ultimate goals when we try, as we often do, to steal the best people from those other disciplines. We believe, for instance, that a pediatrician can in his own work make tremendously effective use of psychiatric insights and skills in a way that would be impossible for a psychiatrist, and in a way that also becomes impossible for him if he tries to shift his rôle to that of a psychiatrist. The same can be said of a nurse so long as she uses her psychiatric training to become a first-rate nurse and to train other nurses, rather than to assume the rôle and the techniques of a social worker. What we are saying, in other words, is that psychiatric training is necessary for the non-psychiatric disciplines in order to increase their own effectiveness, and not in order to substitute them for scarce psychiatric personnel.

In summary, we wish to state that the National Mental Health Act, in its aid to states, is already contributing significantly to the country's health program, but that it is at this point very far from being utilized with maximum effectiveness. As a generalization, we have found the best state programs to be those that do long-term planning, and particularly those that stress the training of competent staff and the development of training facilities.

THE RESPONSIBILITY OF THE LOCAL COMMUNITY FOR A MENTAL- HEALTH PROGRAM *

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THE most recent evidence of man's ability to mobilize positive and constructive forces in his own behalf is the encouraging development of the World Mental Health Movement. We, who have been working within the boundaries of a local community, have gathered strength as we have proudly witnessed the progress being made in state, national, and world mental health.

In recent years, psychiatric services have been made possible in areas in which the population has never seen a psychiatrist. Training of personnel and research have been stimulated. These are truly remarkable achievements. But such achievements can become mixed blessings and may even be lost entirely if we do not recognize our responsibilities and devote our attention to the consolidation and advancement of our gains.

Our state and national leaders have repeatedly advised that the job cannot be done by top leaders alone; the battle for mental health cannot be won by mental-hygiene generals. Even generals require supplies and forces that must originate in the local community.

The conservation of human resources and the improvement of facilities for the treatment and prevention of mental illness have been recognized as a concern of our citizens whether technically trained or not; and the persistent translation of such concern into well-defined areas of action is a primary responsibility of the locality. Although we have come to realize that mental health, like democracy, must encompass wider horizons, mental health, like democracy, begins at home. It, therefore, seems appropriate to describe some

* Presented at the session on "The National Program for Mental Health" at the Thirty-ninth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 3, 1948.

of the efforts being made by a local community to meet this challenge.

The Cleveland Mental Hygiene Association is a voluntary organization supported by the Community Fund. About two years ago, we did what many organizations do from time to time. We paused to take stock of ourselves as a group and achieved a more sharply focused sense of direction. While the state and the federal government had a large over-all planning job and could meet but a fraction of our needs, it was clear that the really big job was ours. Ours was the responsibility of promoting the intensive development of our own resources. Ours was the job of finding out what we had and what we did not have. Ours was the job of probing, planning, educating, and acting. The kind of help that would be required from the state and the federal government would in large measure be dependent on what we understood of our *own* community's needs and the extent to which *we* could meet these needs.

We could see with greater clarity that we must work closely with citizen groups of other localities and with state organizations, in a coördinated effort to accomplish our common goals. We could see with greater clarity that we must function in our community as a part of the fabric of health, welfare, and public education.

An inventory revealed needs that can hardly be called unique. They started with the improvement of conditions in the state mental hospital and ran the gamut through to the improvement of human relations. Reaffirmed was the logic of supporting programs promoting the training of psychiatric and auxiliary personnel; reaffirmed was the need to develop psychiatric wards in our general hospitals, to strengthen and expand child guidance and related social services, to encourage and strengthen psychiatric services in the school systems, in the courts, and in industry. Mental deficiency and a number of other serious problems were marked for attention.

Considered to be of major importance was the need for an intensive program of community education aimed at (1) providing the public with the facts about the shortage of treatment facilities; (2) exploding popular fallacies about the nature of mental illness—both the fallacy of incurability and

the fallacy of quick cures; and (3) fostering the application of mental-hygiene principles to everyday living—in everyday language.

In such an educational effort, the maintenance of an active working relationship with the local newspapers was recognized as essential. Also to be utilized were motion pictures, radio, and popular literature, with special emphasis on group discussion.

When we have so wide a range of community needs, with a staff consisting of the director and an office secretary, two things become obvious: first, the necessity of being selective in choosing areas of work; second, the crucial need for citizen participation. To a large extent we must be guided by the degree of current interest in finding a solution to a problem. It is this type of interest that frequently brings with it a citizen group highly motivated to work out a solution. It was this type of interest, expressed by persons close to our organization, that led to the formation of the various committees and groups now carrying the major burden of our work. We will touch briefly upon the development of some of these committees.

In response to frequent questions involving the location and policies of psychiatric clinics and hospitals, a committee was formed to compile a directory. The committee is composed of members of the American Association of Psychiatric Social Workers, and is headed by a board member who was formerly employed as a psychiatric social worker. The compilation now nearing completion has provided a more accurate picture of the function and scope of our facilities. A valuable by-product of this activity is the information obtained about waiting lists, work loads, and plans for future expansion.

An attorney heads another committee whose job it is to strengthen mental hygiene in the schools. This committee, in coöperation with other groups, was largely instrumental in persuading the school authorities to create the new position of psychiatrist in the health division. When a psychiatrist is appointed, it is planned further to develop the child-guidance program. Inservice training, to help teachers develop a deeper awareness of the emotional needs of children, is to be a major goal.

The number of calls received from social agencies, psy-

chiatrists, and attorneys expressing impatience with certain commitment procedures as being unnecessarily traumatic for patients led to the formation of a committee designed to improve the procedure. Its membership is composed of attorneys and psychiatrists. Starting with points of view that were quite divergent, these two groups have reached points of agreement—and without bloodshed! A proposal for remedial legislation to make it possible for certain patients to be hospitalized without going through a judicial procedure is now being drafted.

Like many communities faced with the problem of mental deficiency, we have expended much energy in urging the construction of additional state facilities for cases that require institutional care. Although some progress has been made and a new state training school is now being completed to relieve some of our pressures, we do not pretend that the problem is very much closer to a solution. Hampering a community's efforts to make progress in this area is the difficulty of altering the rigidly held idea that the mental defective is categorically a state responsibility. Ignoring tradition, one courageous group of citizens established day-care centers in settlement houses and churches to offer mentally deficient children excluded from the public schools a group experience that provides acceptance, recognition, and satisfying activity. Reaching out to this group, which had been struggling in virtual isolation, a committee sponsored by our organization recently voted to recommend that it be brought into the family of recognized agencies in the Health Council of Welfare Federation.

Where should the community concentrate its efforts in the development of psychiatric facilities? To what extent in child-guidance clinics, in general or state hospitals, in the training of psychiatrists, psychologists, nurses, and psychiatric social workers? What is sound mental-hygiene education? Should the state mental-hygiene program be in the welfare department, in the health department, or in a separate department of mental health? To render guidance on such and other technical questions, the administrative heads of the major psychiatric facilities in Cleveland rallied to our request for a psychiatric advisory council. This group

has given generously of its time and has made valuable contributions in community planning.

We have thus far described committee work performed by a relatively small group of highly motivated citizens engaged in study, planning, and step-by-step action.

What efforts have been made to secure a broader base of community participation? A fitting illustration is our effort to do something about the frequent exhortation that the state hospital and the community must be brought closer together. A major concern in our community for years has been the overcrowding and under-staffing of Cleveland State Hospital. It received a heavy dose of attention stimulated by a series of articles written by Walter Lerch, of the *Cleveland Press*. Subsequently conditions were graphically portrayed in *Life* magazine. Investigations followed. When the smoke had cleared, the hospital was still standing as it did in 1865. To be sure, crowding had been reduced to some extent, and a new superintendent had been appointed. A visit with our broad-visioned superintendent soon revealed that the problem of personnel was still acute. If his staff were doubled, the hospital would just begin to meet minimum American Psychiatric Association standards. In all the fuss and fury, this most essential of problems was quietly forgotten. A visit through the wards told the story. There were wards with 50 and 60 patients—and one attendant. Under the new superintendent, there had always been an "open door" policy, but the opportunity was not utilized to any appreciable extent.

Following a report to our board, there ensued a series of well-prepared visits never before experienced in the history of the hospital. A group representing our board of trustees, committees representing a number of women's civic organizations, Parent-Teacher Association clubs, and church groups toured the hospital. At the end of each tour the group would invariably meet in the superintendent's office to discuss their observations and to inquire about the hospital's needs. The answers given left little room for doubt as to the connection between inadequate legislative appropriations and the grim shortage of personnel. Among other things, shortage of personnel meant that not even one case-worker could

be assigned to supervise hundreds of patients out on trial visit. The tour provided what no conveniently written account could—visual aids of a stirring quality. Letters and verbal appeals to legislative representatives acquire significance when based upon such living experience.

With the assistance of citizens who had been through this experience, the most dramatic and unprecedented of tours was arranged. In recognition of the simple truth that legislation begins in the minds of men and women who are interested in doing the right thing—particularly when they are encouraged to do the right thing by the voters—a tour by the entire county delegation of the state legislature was arranged. There were few absentees. Some of our legislators even indicated a special desire to be marked present.

There are delectable details about this tour which we will have to forego. Although it would oversimplify the situation to credit subsequent events to this visit alone, it is significant to note that out of this same group of legislators have recently come a series of courageous recommendations for fundamental changes in the administration of the state mental-health program. Unless I am mistaken, this is what Dr. Stevenson meant when he said that legislation does not begin in the halls of the state capitol.

And what of the other groups who came to see and inquire? Several groups and individuals have decided to render volunteer services to such an extent that consideration may soon be given to setting up the job of coördinator of volunteer services.

Upon request of the chief occupational therapist, a prominent women's club acquired a supply of cosmetics, obtained the coöperation of one of the local beauty salons, and gave a "cosmetics party" in one of the female wards. Never having visited a mental hospital before, the clubwomen came with much trepidation. They felt awkward in the presence of suspicious psychotics. Cosmetics and hair restyling were given to the more venturesome patients. Punch and cookies were served. Patients became less suspicious and more friendly. Fear of patients diminished. Reporting to me about this event, a member of the club wrote: "Yes, it is true of all us women, sick or well—a new hairdo, a new lip-

stick can make such a difference in our lives. It gives us all a lift. And each lift a mentally ill patient receives from us citizens helps them that much more." What better way is there to lend credence to our repetitious exhortations that mental patients are human and responsive to kindness?

Some groups are finding much satisfaction helping in recreational-therapy departments, and others have been sponsoring in community stores the sale of articles made by patients. These are but a few examples of volunteer activity in a hospital that can indeed use a lift.

While the citizen volunteer renders a significant service, what is of immeasurable value is the substantial acquisition of facts about the hospital's needs that he can discuss intelligently with others.

Some groups have been busy visiting clinical and social resources in the community to learn how they operate. Others have sponsored a series of lectures on mental health and have conducted discussion groups.

The desirability of coördination of this vital group effort became increasingly apparent about a year ago, after the sordid murder of an eight-year-old girl by a psychopathic delinquent. In the intensive search for the offender, police found living in the community hundreds of individuals who were obviously suffering from mental disorder. Newspaper accounts of the situation led to such preoccupation with the problem of mental illness that our phones rang incessantly. Requests were made for talks explaining the implications of the tragedy and of the disclosures made by the police concerning the large incidence of mental illness.

Our talks contained nothing new or unique. Many were startled by the extent of unmet needs. A frequent question was, "What are *they* going to do about it?" This is a crucial question during such a meeting. Staying with the question up to the point where the group begins to be aware that *they* are *we* is an essential preliminary for responsible action. It was Dr. Gregg who so succinctly made this point last year.¹ In each group discussion, an effort was made to describe the natural tendency to plunge into action now and

¹ See his article, "The People's Program," in MENTAL HYGIENE, Vol. 32, pp. 1-3, January, 1948.

to lose interest after society's liquidation of the offender. The futility of action based on spasm and crisis alone was pointed out. Emphasis was given to the need for sustained interest and activity even when murder takes a holiday. The implied objective was the setting up of a mental-hygiene committee in each interested organization.

To-day, twenty-five outstanding groups, representing thousands of citizens, are organized into the Cleveland Council for Mental Hygiene. Two delegates are sent by each group to the council, which conducts a forum each month on pertinent mental-hygiene problems. Now in its eighth month, the council has begun to show promise as one possible pattern for widespread community education and coördinated action.

In the limited time available, we can do little more than touch upon one phase of our attempt to encourage the widespread application of mental-hygiene principles to everyday living. Our efforts in this area have been aimed at what Lawrence Frank has called the "cultural agents" in the life of the child—parents, teachers, public-health nurses, doctors, recreational and religious leaders.

The importance of participation by such individuals in planning an educational program may be illustrated by the method we used to develop a film library. Key persons from the various walks of life just mentioned were invited to preview films, to help us decide whether they were sufficiently useful to justify purchase. Over a period of months they participated in the decision to purchase *Feeling of Rejection*, *Your Children and You*, *Let Your Child Help You*, *Problem Child*, *Shy Guy*, and several others. A public-health nurse discussed one of these films at her staff meeting and the entire group of about seventy assembled to see it. The showing was followed by a discussion that lasted well over an hour. The eagerness for further discussion was so apparent that the administrator of the group proceeded to make arrangements through the local school of nursing for a series of psychiatric lectures.

Organizations such as the Parent-Teacher Association have shown considerable interest in these films and in Dr. Woodward's recorded programs.¹ They rarely fail to provoke

¹ For a list of these programs, see MENTAL HYGIENE, Vol. 32, p. 684, October, 1948.

lively discussion. A volunteer panel of professional persons has been helping to meet the growing demand in this phase of our educational program.

In the foregoing account, describing an attempt to assist the citizens of our community to assume and to retain responsibility for its mental-health resources, we have been guided by a number of principles. It may be appropriate at this time to mention briefly a few:

1. The rôle of leadership is that of assisting the community to work out solutions of its problems in a manner and at a pace appropriate to the area. The leader is a catalytic agent and guide rather than a person who takes total responsibility.

2. There is need particularly, in so wide and complex a field, to break down a problem into discernible and easily defined areas.

3. Constant thought must be given to next steps in procedure and continuity.

4. There is constant need for awareness of prevailing psychological mechanisms that tend to block progress, and for efforts to facilitate the modification of these mechanisms. For example, the tendency to project blame onto others for inadequate mental-health facilities should be recognized for what it frequently is—an effort to relieve guilt and a rationalization for doing nothing. (This should not be confused with responsible constructive criticism.) There is need to mobilize concern before emotional catharsis has been effected. People can be led gradually to a recognition that *they* are *we*, and that *we* can take positive steps.

5. It is important to know our citizen volunteers, their talents, their interests and time pressures, in order to find the right job for the right person. This results in a genuine feeling of usefulness and a higher percentage of completed jobs.

These principles, drawn from a variety of disciplines, suggest the question: What types of qualification should we expect to find in the professional leader charged with the responsibility of day-by-day community planning for mental health? There are many perplexing facets to this question which can be answered only by basic research. It will be a long time before the question is settled. But in the mean-

time, we must not lose sight of our obligation to increase the number of trained community leaders in this area by opening our mental-hygiene societies, whenever circumstances permit, to provide field-work placements for students in the graduate professional schools.

In conclusion, I should like to emphasize the need to perceive our opportunities and to retain as much responsibility as possible for the development and the improvement of our human resources right in our local communities. In view of recent developments that have brought increased responsibilities on the state, national, and world levels, it is more urgent now than ever before that we do not succumb to the delusion that others will do the job for us. Our correlated goals of mental health and peace in the world depend upon what the citizen thinks, feels, and does in his own home and in his own community.

PERSPECTIVE ON NATIONAL HEALTH PLANNING *

QUINCY HOWE

News Analyst, Columbia Broadcasting System

LET me be the first to congratulate you on your choice of myself as the speaker at to-day's luncheon meeting. Since many of you here are familiar with the general field of psychiatry, I cannot imagine a more fascinating object of clinical study than a radio commentator the day after Governor Dewey conceded the election of President Truman. Quite apart from the unexpected turn of events during the past forty-eight hours, you were perhaps well advised to turn to the radio field for a speaker, because it is just as true of radio as it is of the movies that you don't have to be crazy to go into the radio field, but, as in the movies, it helps.

I open these remarks with a little attempted humor, partly in the hope of trapping your interest in the rather dull remarks that are to follow and partly because these opening comments really have a perfectly serious bearing on the reports that have been made before The National Committee for Mental Hygiene—reports that I am about to summarize. I have been sent a batch of reports. I don't know whether I got them all. I am going to refer to all that I have received. Those of you who did not hear these reports delivered I am sure can get copies of them, so I am not going to waste your time or insult the intelligence of the authors of the reports by trying to rehash what they said much better than I can. Instead, I will just pick out certain points that certain speakers made and try to show how it seems to me they fit into a general pattern.

During the past year and a half, I have been broadcasting science news on the CBS program called "Frontiers of Science." My only qualification for this task was that I knew absolutely nothing about the technical matters that I discussed. Most popularizers do know a little something about science

* Presented at the luncheon of the Thirty-ninth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 4, 1948.

themselves and as they begin to popularize it, they learn more and more, and finally they know so much that nobody understands what they are talking about. I never learned quite as much as that, but after a year and a half, I was beginning to pick up a little of the lingo, and CBS very wisely decided to take "Frontiers of Science" off the air and put me on a new series of programs, on a whole lot of subjects about none of which I know anything. So I will be very readily understood by the average radio listener. But before the slight knowledge I have acquired about science during the past year and a half slips entirely away from me, I welcome this chance to recapitulate just a little of what I have learned, with special reference to the serious subject that draws us together here.

I have always felt that the release of atomic energy did not mark the beginning of a new era, but the end of an old one, because for the past several centuries, the physical sciences at any rate have received a lot of attention and have concentrated a great deal on developing new sources of power—steam, coal, electricity, oil—and now finally have tapped the power of the universe itself, the power of the atom. Tremendous possibilities, of course, lie ahead in applying the new power to factories and transportation and heating; also, it is being applied already to the medical sciences. But I think the new field of research, the real advances lie in other quarters. They lie in the realm, for instance, of the biological sciences which stand more or less to-day where the physical sciences stood one hundred and more years ago.

The next great goal in the biological sciences—and perhaps the great goal in science itself—is the discovery of the secret of life. The object of study of the biological sciences is the living cell, just as the physicist studied the atom, and the great hope there is that perhaps some day man might actually be able to create life in a test tube. If he can do this—there is no assurance that he can—man will have gone a long way toward making himself almost immortal.

The second field that is now receiving a great deal of attention is the whole field of ecology, the study of man's physical environment on this earth. Fairfield Osborne and William Vogt have come out with two new works, of which Mr. Osborne's *Our Plundered Planet* is perhaps the more famous

of the two. They have reminded us of our vanishing resources, our diminishing top soil. Mr. Vogt, in *The Road to Survival*, has suggested that perhaps the Malthusian law, which all the economists scoffed at for a long time, is going to have to be accepted, or at any rate reconsidered.

Certainly this whole question of vanishing resources received top attention at this year's centenary meeting of the Association for the Advancement of Science. Some of the delegates at this convention, though, said that this fear of our vanishing resources was really rather a sign of the inner fears of the people who were spreading these doctrines and trying to arouse us, and that what we really need is to repair ourselves instead of the world around us. That, of course, is the field to which you here are devoted—the field of psychiatry.

Closely allied to that is the fourth field of sociology, the relations between man and man, and between man and his environment. This is probably the most extensive of all the new scientific fields. But if sociology is the most extensive, I think psychiatry is probably the most intensive.

All these new fields suffer from what you might call the defects of their qualities. New branches of science seem to have a way of attracting to themselves rather large numbers of charlatans and phonies. There are fewer established standards in these new, unexplored fields; there are limitless possibilities, and if anybody uses more jargon than the psychiatrist, it is the sociologist. At the other extreme, of course, in the sciences stand the two oldest and most firmly established—mathematics and astronomy. Each has been called the queen of the sciences. There is no room for phonies in either. Astronomy used to be astrology, but as it became more definitely pinned down to a precise field, the astronomer had to be just as precise as the mathematician.

There is plenty of room for development in these two fields, but the possibilities are perhaps more limited than in the newer fields of psychiatry and sociology. You who are concerned primarily with mental hygiene, not exclusively with psychiatry, find that psychiatry reaches out in many directions and that your work takes you even further because you are concerned, as the speakers who have been heard here

to-day have shown themselves to be concerned, with the whole community; and so you are willing to listen to sociologists, and even, apparently, to a radio commentator.

You have heard that all the sciences are coming closer together, and that is true. They are depending more and more upon one another because of this very fact of specialization. The fact that science has specialized so much and so intensively means that no one man can know all the answers. You, for instance, certainly have much to learn from the science of biology, and the science of biology in turn may have to learn from the science of chemistry. None of these sciences can stand alone.

Then you also see—and I think Dr. Aldrich's personality brought that home to all of us very strongly—what really to my mind is the breaking down of the old imaginary barriers between science and religion. A man like Dr. Aldrich is primarily, I think we all felt, a spiritual figure rather than merely a figure in the field of what we think of as science. Certain extreme materialists used to ridicule Jeans and Eddington because they seem to take refuge in mysticism, but extreme fundamentalists also oppose the more liberal creeds which do not insist on literal acceptance of articles of faith, but pay more attention to the spirit of the religious man. Many of those who followed the sciences were perhaps not aware of what I have just said of the religious field.

I am a Unitarian myself. I sometimes think we Unitarians are the real fundamentalists of the Christian religion because we go directly back to the words of Jesus himself, whom we consider as a man and not something divine, but as a human being by whom everybody can be inspired. We apply these principles—or hope we do—just as other religions try to apply the teachings of such figures as Buddha, Confucius, Moses, and the rest. Furthermore, I think the feeling is growing that the divine principle really runs through everything, and that immortality may lie in what we do here and now in the world around us and on its infinite continuing effect on the world around us and the world after us.

But the point really is the spirit in which we approach this work, and the work that an organization like this one is attempting conforms, I think, to the true spirit of all great

religions just as it also draws from the findings of every branch of science.

Let me just show from some of these papers that have been presented here how true this is. Your medical director, Dr. George Stevenson, devotes his annual report¹ to the need, among other things, of getting more than a million members, one for each person now suffering from some mental disorder. Well, if this isn't a crusade, I don't know what is. He showed the importance of getting local and state groups into action, the need for publicity and education. His program, however, is going to work only to the extent that you and hundreds of others like you go out and see that it is made to work, and if you are going to do that, you have got to have faith, you have got to have hope, and you have got to show charity.

Samuel Whitman brought you a similar message.² He spelled out your work in terms of the local community. He called attention to the city of Cleveland, where the Community Fund supports work in behalf of mental health. He wants the public to know more about the shortage of workers in this field. He called attention to certain popular fallacies about the nature of mental illness—the fallacy that mental illnesses are incurable, the fallacy also of quick cures. He said that the application of known principles of mental hygiene have got to be applied to our daily lives.

Then there were a couple of papers on "Mental Health Bridges" that went into greater detail.³ Mrs. Marjorie Franks discussed what volunteer workers can do. She mentioned that the National Council of Jewish Women and the Society of Friends have provided some helpers, but that many more are needed. Note that both of these organizations have religious affiliations.

Marian McBee, in her paper on citizen responsibility, paid tribute to the current motion picture, *The Snake Pit*, for what it has done to publicize the conditions in our mental hospitals and the hope for cure of mental disorders. Miss McBee also pointed out that there is not a single state in the Union that pays the five-dollar-a-day minimum that the American Psy-

¹ See pages 1-8 of this issue of MENTAL HYGIENE.

² See pages 51-60 of this issue of MENTAL HYGIENE.

³ Papers mentioned here that do not appear in this issue of MENTAL HYGIENE will be published in future issues.

chiatric Association says should be spent on every mental patient. So you are in politics, too.

We tend to isolate our mental hospitals—not only the inmates, but the doctors and the nurses—and it is necessary to make them feel that they belong to the community and that we also have affiliations and connections with them. Dr. Newton Bigelow made the same point in greater detail when he called for a more judicious opening of the doors of our mental hospitals to the public.

As we know, there are two worlds right around us all the time—the world of the sick and the world of the well. We will not have anything that could really be called one world until those two worlds get a bit closer together than they are.

After all, every religion worthy of the name and every moral and ethical principle that we try to live by and try to teach our children tell us that just for our own good—not for the good of other people, but for our own good—we must concern ourselves with less fortunate members of the human race. “There but for the grace of God, go I,” we should always say to ourselves every day. Dr. Bigelow, however, concentrates on practical suggestions. He hopes to see the Gray Ladies of the American Red Cross pay greater attention to mental hospitals. The big thing is to overcome our fear of the unknown. Even a good many doctors apparently need to know more about mental cases.

This is more or less the negative side of the picture—the preventive work talked about here earlier, the kind of work that needs to be done in connection with people now suffering from some mental ailment or other. To care for these people, we need to apply the virtues generally associated—I say generally associated—with the teachings of our religious and moral leaders. It is not enough just to minister to a condition that is getting worse and worse. Science, in so far as it has a contribution to make—and it has a tremendous one—is constructive. It is practical. It deals with the material things in the world of the here and now. You all know the figures on the prevalence of mental disorders in the United States—how they are costing more and more, how they are more and more of a burden, and how what we need is prevention much more than cure.

Dr. James V. Lowry told how the National Mental Health Act works.¹ He described the new government projects going forward at Bethesda, Maryland. He made it clear that the federal government is willing to help states and smaller local groups with grants-in-aid. The National Health Assembly which met in Washington earlier this year, in the spring, marked a big beginning in this way. The American Medical Association, although it disapproved some of the items in the final report that came out, took a great step forward and had a big part in the deliberations of the assembly, participating in its work all the way through. Mental health was one of the topics covered.

Miss Elizabeth Gordon Fox's paper on "Teamwork for the Young Child" gave a lot of excellent practical advice. She warned that the obstetrician, the baby doctor, the public-health nurse must work together as a team to keep expectant mothers and young mothers in the right frame of mind through the whole period of pregnancy, delivery, and early care of the child. Here, again, is a psychiatric problem. The chief enemy is fear for the baby's welfare, fear of one's own inability to rise to a difficult job on which so much depends.

None of the papers that I read interested me more than Dr. Weston LaBarre's, on the "Age Period of Cultural Fixation." It sounds like a dull title, but, believe me, the paper is not dull. Writing as an anthropologist, Dr. LaBarre showed how different methods of bringing up children among various primitive tribes create entirely different kinds of culture. Perhaps it should be put the other way around—that different cultures require and involve different methods of child education, but either way the point is the same. The way we bring up or train our children determines their characters and their whole lives. Dr. LaBarre made several quotable statements which I wrote out to read here: for example, "The single, most important thing in human cultural behavior is literally and specifically the way we bring up our children"; or again, "No human being is ever maladjusted to thin air, but only to the specific cultural and moral demands of a given society."

I remember reading a paper a short time ago in one of the scientific journals about juvenile delinquency. It pointed out

¹ See pages 30-39 of this issue of MENTAL HYGIENE.

that in certain areas in which juvenile delinquency is still the rule rather than the exception, it is the normal child who is a juvenile delinquent. The well-behaved child is the one who needs the attention of a psychiatrist. Dr. LaBarre says also, "A functional mental illness is a disease of the mind primarily, not of the brain. It is a disease of the social animal, not of his body."

A lot has been said about frontal lobotomy, brain operation, and what it can do to cure psychiatric difficulties. This, with drug treatments and the rest, of course helps, but it is evidently not the whole story by any means. The problem is a social problem. Dr. LaBarre pointed out that the Chinese, who do not seem to suffer from hypertension, are that way not because they live on a diet of rice. Plenty of Americans eat rice and get quite high-strung. The reason lies in the cultural behavior that the Chinese have followed for thousands of years.

Finally, Dr. LaBarre said: "The important differences among groups of men are those of their value systems—the things they believe in, their attitudes and behavior, in short the things they want to be." In other words—as I have often heard said and have said myself time and again—it is not the facts that determine the way men or nations or groups act; it is what we believe to be the facts.

What is true of individuals is also true of nations and groups. Alexander H. Leighton showed how whole societies suffer from common cultural symptoms.¹ He warned about vicious cycles in human affairs. I cannot help applying that idea, that approach, to our relations with Russia at the present time. I am sure we would agree that the fundamental problem of ourselves and the Russians, like many other problems, may well be psychiatric or psychological. How are we going to get along over the years if we bring up our children in a certain pattern and the Russians bring up their children along an entirely different pattern—if these beliefs and ways of life are instilled into a whole generation? Are you not going to get a new kind of culture and a new kind of human animal emerging? Is there a way out of all this?

Margaret Mead's report² on the World Congress of Mental

¹ See pages 17-24 of this issue of MENTAL HYGIENE.

² See pages 9-16 of this issue of MENTAL HYGIENE.

Health in London is perhaps the most hopeful of the papers presented at this meeting that came to my attention. Dr. Mead showed that scientists of all nations and people who were not scientists worked together on common problems, sharing their knowledge and seeking the same goals.

The real truth, coming back to science, is that science is playing a good deal—in fact, more and more—the part that religion used to play, but it will succeed only if it keeps the spirit of religion and adds to that the consistent, fearless, steady search for the truth. We stand perhaps only at the very beginning of a great awakening. We need a much greater perspective than we have got on what is going on in the world around us. How wrong we can be, even about the most simple things, was shown just yesterday, to the total surprise of almost everybody, at the outcome of the national election. But it may be that the really big thing that is happening is not in the papers at all. Perhaps it is changes that are going forward in our own minds, changes that we see and have brought home to us in facts like those about the high rate of nervous and mental disorders among the people who are now registering for the draft.

Well, you people here in The National Committee on Mental Hygiene are doing, it seems to me, a work of double importance. First, you are getting together on a human-welfare basis, the welfare of fellow beings, fellow human beings, a cause that is something outside and beyond yourselves. You are not being offered happiness or comfort or wealth or anything else, but satisfaction in a worth-while job well done. You are also joining with other human beings in a common work, and there is nothing that gives people more satisfaction than that of working together, because man is a gregarious animal and likes to take part in group efforts and not just to operate alone.

Secondly, I think you are taking part in one of the most important crusades that modern science has ever attempted, if not the most important. It is like this question of the atom. To apply our knowledge of atomic energy is of course still an enormous job, but in that those who study the nature of man himself and the behavior of human beings have the crucial rôle to play.

The new frontiers of science are now becoming more and more concerned with man himself and are focusing on man. After all, the words of Shakespeare still apply, "What a piece of work is man!" What a piece of work you have cut out for yourselves here. And how pleased I am that you have let me take this little part in it to-day.

COMMUNITY EDUCATION THROUGH PRESS, RADIO, FILMS, AND DRAMA *

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IN order that mental hygiene may make the contribution of which it is capable, it is essential that some of the insights of psychiatry and the psychiatrically oriented professions should become familiar to greater numbers of people. As one means to this end, more people must know about the field of mental hygiene, so that they will give it the kind of support, financial and otherwise, that is required if it is to accomplish the job ahead. To a certain extent, this means becomes an end in itself. In trying to picture the total job of mental-hygiene education, it is important to place both means and end in proper perspective.

To elaborate, the final end or purpose of mental-hygiene education is to teach understanding about human behavior and human relationships. This requires proper facilities and trained personnel, which in turn require money and citizen support, and these will be given only by people who know what mental hygiene is and what it is trying to do. Therefore, informing people about what mental hygiene is becomes a secondary end in itself.

It is one thing to make suggestions to a mother about ways of handling her children; that is an example of the final or major purpose of mental hygiene. It is something else to persuade a group of citizens to give money to establish the clinic or program to which the mother can go for assistance with her children; that is an example of a means to the primary purpose, which, as already stated, becomes an end in itself—let us call it the secondary type of purpose or end.

Strangely enough, there is considerable confusion about these two types of purpose, and many community programs have not been well founded because of failure to distinguish

* This paper was given at one of the Specialist Meetings which were held at the International Congress on Mental Health in London, 1948. The Proceedings of the Congress will be obtainable from the Publications Department, The International Congress on Mental Health, 19 Manchester Street, London, W. I.

clearly between the two. That is not to say that there is a sharp line between them. There is not. They overlap at many points. For example, the best approach to the group of citizens might be to teach them the same things that the mother is being taught, so that they can experience for themselves some of the values of mental hygiene and, therefore, be more willing to support it. Furthermore, one utilizes the same methods of reaching people for the two different purposes. For good community planning, however, it is important to have the distinction clearly in mind.

It is also important to have the distinction in mind as a defense against the "ivory-tower school" of thinking among professional workers in mental hygiene who are scornful of the disagreeable business of fund-raising or obtaining community support of any kind. Actually, the time has come when mental hygiene absolutely must make itself known to more people. It must have more funds, more personnel, more facilities of all kinds. Under these circumstances, getting one's name before the public becomes an end in itself, and a laudable one.

People will not give money to something they have never heard of before—as any one can testify who has tried to raise money for a mental-hygiene program. There was a period during the fund-raising campaign for the International Congress on Mental Health when the outlook was very precarious indeed, and the complaint heard over and over from finance-committee workers was that the people from whom they were expecting substantial gifts "had never heard of mental hygiene." These are the circumstances under which a two-inch squib in a newspaper is sometimes more effective than hours of persuasion by a friend of the cause.

Therefore, we propose here to make short shrift of the previously mentioned "ivory-tower school." Publicity has its proper place. Granted, it is full of pitfalls and possibilities of abuse. This is not the place to discuss those. When thoughtfully, honestly, and intelligently used, it is invaluable. Most of us in mental hygiene have had neither the interest nor the opportunity to learn how to manipulate publicity. We can no longer afford to escape into our naïveté. Publicity should be regarded as part and parcel of the total job in mental-hygiene education.

Let us agree, then, for the moment that community education in mental hygiene has two aspects: the primary goal of teaching people about behavior and relationships, and a secondary goal—which is really a means to the first—of informing them about the mental-hygiene field in order to obtain necessary support. What are the best methods to use? Clearly, they must be methods that will reach large numbers of people. This means utilizing what will, for lack of a better phrase, be called the media for mass communication—press, radio, films, and the drama.

It is the workers in these fields who have developed skill in interpretation and who know the ways of reaching large numbers. Professional workers in mental hygiene and the social sciences are often remarkably inept at interpreting their own material. They do not know how to say things in ways that will get across and they do not have the channels for reaching large numbers. These other workers in the fields of communication—newspaper reporters and columnists, editors, magazine writers, script writers, radio and film producers, dramatists—these are the people who influence millions. A good working relationship between these two fields is advantageous to both. The workers in communications may profit from consultation about the psychological soundness of some of their material, and will also get new material of a type for which their public is reaching out. The workers in mental hygiene obtain the advantage of other peoples' skills in interpretation and the opening up of new channels of communication.

When, as in this instance, it becomes important to build a working relation between two groups, it is sometimes helpful to analyze the snags. A few of the writer's observations about relations with the press will serve to illustrate the principles involved. From the point of view of many professional people in the social sciences, the press is a necessary—or an unnecessary—evil, consisting of reporters who are irresponsible, uninformed, indifferent to accuracy, and avid for the sensational (often spelled s-e-x). From the point of view of the press, social scientists are often extremely poor copy because of their hifalutin' jargon, their inability to suffuse their material with life, and their lack of awareness of what is and is not of interest to the public. Not only the press, proper, but the "go-betweens" selected by the social-science group to repre-

sent them with the press often find their own employers uncoöperative. It is a frequent and bitter complaint of the press officer (or director of publicity, or public-relations counsel, or whatever he may be called) employed by a scientific group for a meeting or some other project, that he is unable to extract papers in advance from the scientists, that they are not helpful in press conferences, and that they fail to provide him with the material he needs.

To one standing outside looking in, it seems that the faults of both groups are equally reprehensible—and equally remediable. It is understandable that professional workers should be press-shy. They quite justifiably resent sensationalism, and may have had mortifying experiences in seeing their material garbled. Many of the faults of the press, however, can in time gradually be improved by a different attitude on the part of the psychiatrically oriented professions. The secret lies in regarding the press as an indispensable ally, a colleague in interpretation, an integral part of any program of mental-hygiene education. With this change in attitude, social scientists will lose their indifference and their touchiness, and will begin to examine ways of working *with* the press, instead of ignoring it.

A first step toward informing the public about mental hygiene is to inform the press. Often the reason why a representative of the press seems distressingly ignorant is because no one has bothered to give him the essential background. The best way to see that he does not use poor material is to give him good material. When a psychiatrist, for example, takes time to work out with a newspaper man what subjects or "angles" are appropriate and what are inappropriate for a newspaper and *why*, each learns something about the other's field that may be important to him later. Meanwhile, perhaps the psychiatrist, while working toward better reporting, can afford to be a little more lenient with a certain amount of inevitable inaccuracy in news columns and with some of the undignified language and catch phrases dear to the hearts of newspapermen.

Within the press is a growing nucleus of reporters, columnists, and editors who care deeply about mental hygiene. Some of these have informed themselves so thoroughly that they have become mental-hygiene authorities in their own

right. Ten years ago such people were the greatest rarity. Now we are finding them in many different cities. They are staunch allies and should be cherished. Mental hygiene could not list a more valuable asset. In this twentieth century, many jobs have become so complex that they can be handled only by people whose experience spans two different fields. Here we see that people grounded both in journalism and in mental hygiene can make a contribution to mental hygiene that workers in either field alone cannot make.

What has been said here about relationships with newspaper writers and editors is also true of magazine writers and editors. The popular magazines have an enormous ready-made audience. Readers of the women's magazines, for instance, are a "natural" for the inculcation of good mental hygiene. It, therefore, becomes a responsibility of the psychiatrically oriented professions to try to improve the quality and increase the amount of good mental-hygiene material appearing in popular magazines. Editors and writers often welcome assistance in discriminating between good and poor mental hygiene, and may be open to lessons in accuracy and soundness.

These same principles about learning to utilize the press apply equally to learning to utilize radio, films, and drama. Here again it is a problem of adapting the skills of people experienced in mass communications to the interpretation of mental hygiene. It is distressing to observe how often straight mental-hygiene material on the radio is unbearably dull. This need not be so. Radio offers devices for presenting mental hygiene with superb effectiveness. The "soap opera" technique is only now beginning to be used for mental-hygiene education and has splendid possibilities for development. Time, patience, enthusiasm, good judgment—these are some of the ingredients that the psychiatrically oriented professions should be prepared to offer to their colleagues in radio.

Films offer two important vehicles—the entertainment film and the non-dramatic film, including documentaries and educational films. The use of the non-dramatic film is reasonably satisfactory, though it is being developed slowly. Some acceleration is to be expected. Here, once more, it is essential that representatives of different fields work together.

The entertainment film is another story. The rash of films about psychiatry such as occurred two or three years ago is

enough to make any psychiatrist wish that Hollywood, having unfortunately heard about psychiatry, would promptly forget about it. However, it is not too much to hope that Hollywood may one day see the desirability of portraying psychiatry accurately instead of inaccurately.¹ Such films could do a stupendous job in education. When that fine day comes, it is to be hoped that representatives of the various professional groups to be depicted (such as doctors, nurses, social workers) will be called into consultation with the film experts.

An area that demands immediate careful scientific investigation is the study of the psychological effects of films on people, especially children. When film authorities do reach out for a little scientific advice—as they are now doing—they are too often handed conflicting opinions based on the scientists' own personal reactions. It is lamentable that we do not by now have a greater body of scientific knowledge about children's reactions to films. These are problems that are not easy and not small, but they are amenable to investigation, and a big contribution needs to be made in this direction.

As to drama, there are the same two divisions as in films—the entertainment drama and drama written for use in education. Entertainment drama has beautiful possibilities for utilizing psychiatric material constructively, and for familiarizing people with words and ideas associated with psychiatry, and conveying accurate psychiatric concepts.

The use of short dramatic sketches in adult education in mental hygiene has been tried out over a period of several years in some joint projects between the New York Committee on Mental Hygiene and The American Theatre Wing Community Plays in New York. A description of that effort will be given elsewhere. Here I will only say that it is meeting with great enthusiasm, and is a particularly interesting example of the ways in which representatives from different professions can learn to work together to the mutual advantage of each.

In summary, it may be said of the workers in media of mass communication that they can get along without us better than we can get along without them. We must have their coöperation if we are to do our job in mental-hygiene education. The

¹ Since this paper was read in London, *The Snake Pit* has appeared—proof positive that psychiatry can be accurately portrayed in an entertainment film.

problem is one of learning to work together. Many of what have appeared to be the faults of these other professions may be modified by a change in attitude on the part of workers in the social sciences. Press, film, radio, drama—these are the mental-hygiene allies of the future.

RESEARCH IN MENTAL HEALTH IN THE NATIONAL PERSPECTIVE *

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THROUGHOUT the day we have had the privilege of listening to some stimulating and challenging discussions of research in psychiatry and allied fields by individuals who are primarily research workers. Several of them have devoted much of their professional life to this activity. In contrast, the presentation this evening is made from the viewpoint of a clinician who rationalizes, on the basis of the pressure of clinical demands, the meager extent of his own participation in investigative work. There may be some argument as to whether the clinician can have a justifiable opinion about a field in which he has had so little experience. There is, on the other hand, the advantage that he may have a degree of objectivity about the field that is not possible for those who are deeply involved in it.

On several occasions¹ I have attempted to express as forcefully as possible my opinion that the greatest needs within psychiatry and its allied fields at the present moment are personnel, a wider public understanding, and research to provide tested knowledge. It is difficult, if not impossible, to place a priority on any of these three needs, which are so very closely interrelated.

On every side, we hear of the shortage of and acute need for not only psychiatrists, but all of the ancillary workers in this field—clinical psychologists, social workers, occupational therapists, nurses, aides, and others. The great demand for the services of these workers, the long training courses they must pursue, and the relatively few adequate training centers give this problem a number-one priority for psychiatry.

* Presented at the Third Annual Coördinating Conference of the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, April 1, 1948.

¹ See "Lessons from Military Psychiatry for Civilian Psychiatry," in *MENTAL HYGIENE*, vol. 30, pp. 571-89, October, 1946; also in the *Bulletin of the U. S. Army Medical Department*, vol. 7, pp. 356-65, April, 1947. See also *Psychiatry in a Troubled World*. New York: The Macmillan Company, 1948. pp. 537-45.

Psychiatry has gained greatly in popular interest and acceptance as the result of experiences connected with the war. There is abundant evidence that, with this interest, the demand for useful knowledge is increasing also. Recently a syndicated article of advice to women casually mentioned The National Committee for Mental Hygiene as a possible source of psychiatric help and advice. As a result, over 2,000 letters appealing for assistance were received.¹ Six weeks ago, a lecture on psychiatry at the New York Academy of Medicine attracted an estimated 2,500 people to a hall that holds 800, the largest audience ever to attend a lecture at the academy.

In indicating a need for a wider public understanding, it is not my idea that psychiatry should be further sold. It is, however, the responsibility of psychiatrists to give the public a body of helpful, usable information which the individual can apply to himself, just as has been done in the area of physical hygiene for many years.

The third great need of psychiatry, research, is also basic, and in the long run it is possibly more important than either more personnel or wider public understanding. This statement in no way minimizes the tremendous gain in psychiatric knowledge during the last fifty years—knowledge that has proven wonderfully helpful in many areas. One might question whether the real history of psychiatry antedates its insemination by the dynamic concepts from Freud. In any case, by its evolution since 1890, it has progressed in its interest successively from pathology to physiology to prevention. Through the application of our present knowledge, we can directly influence the course and duration of many types of mental illness. We now have a workable knowledge of personality structure and function. We have progressed to a position where many positive suggestions can be made toward the maintenance of mental health, through helpful advice to parents, educators, judges, wardens, and to the man on the street.

But with all this progress, none of us should be under the illusion that we possess more than the beginning of the total body of knowledge that we need. In clinical medi-

¹ See "Troubled People," by Sol W. Ginsburg. *MENTAL HYGIENE*, vol. 32, pp. 4-14, January, 1948.

cine we are repeatedly forced to recognize—and should do so with humility—the meagerness of our understanding. Particularly those of us with the responsibility for teaching are constantly aware of the deficiency of our knowledge, of the uncertainty of our concepts, and of the speculative nature of many of our theories. Whether we are teaching about a neurotic reaction or a schizophrenic reaction, we know far too little about the etiology, the dynamics, the treatment.

This lack is expressed in our differences of opinion, the confusion in our language, the variance in the understanding of our basic concepts and attempted interpretations. This fact was brought to me most vividly through my experience in the army, where, because of factors intrinsic in the military situation, we were fast losing ground in carrying out a part of our mission because of the confusion of nomenclature. Not only the military officers, but the public also misunderstood our terminology. This occurred in part, however, because we did not understand one another. The situation forced us to act. In an effort to revise the “standard” nomenclature, we appealed for help from a large number of civilian and military psychiatrists, choosing many of the leaders in our profession. The wide variety of terms, definitions, and concepts was truly amazing and, even though helpful, the end result of our efforts was only a compromise. This experience impressed upon me more forcefully than any other I have ever had the great need for the clarification of our concepts that must come chiefly from research.

What Is Research?—Before going further in this discussion, it might be well to consider what we mean when we speak of research. Certainly the word has a variety of interpretations and usages. This is not merely a matter of semantics; it is also because of varying conceptions, too often not fully appreciated, particularly by many clinicians. Most of the definitions one can find in the literature require paragraphs rather than sentences. Thus Dr. Alan Gregg has described the word, research, as implying a flavor of dissatisfaction with the search made thus far, or with the hitherto accepted explanation. It more than suggests a desire to go back of the extant basis for knowing something. The researcher wants to reexamine the evidence, and this often leads to a refining of the methods by which the evi-

dence was secured. Thus research involves betimes "a critical examination of our sources and ways of learning what we describe as facts." A little further on in his discussion, Dr. Gregg makes the very pertinent point that "research is the response to curiosity, not to need." Characteristically, he takes several paragraphs to point out "what research is *not*, and thus to discard what is commonly mistaken for research."¹

There are various types of research, sufficiently distinct to require different descriptive terminologies. This point was regarded as being so vital that the President's Scientific Research Board,² in rendering its report, attempted to define three general categories: basic, applied, and developmental research. These divisions apply to all scientific research, and because of their implications in psychiatry, it may be helpful briefly to review this classification.

Basic research, according to the Research Board's definition, is divided into fundamental and background research. Background research refers to the preliminary work done before starting a new project. It includes the collection, observation, organization, and presentation of data bearing on the subsequent research. It provides a source of reference material for guidance and comparison. Fundamental research is the construction of theoretical hypotheses, followed by exploration and experimentation that lead to the extension of knowledge. Basic research refers to the discovery of new principles.

The second category is that of *applied research*. After the acceptance of a new principle evolved from basic research, an application is made of it to a specific problem, and the result may be a new process, technique, or product.

The third category, *developmental research*, is the use of one of the new processes, techniques, or products for the specific purpose of testing or applying it in an experimental, demonstration, or clinical field. Developmental research

¹ See *The Furtherance of Medical Research*, by Alan Gregg. New Haven: Yale University Press, 1941. pp. 4, 6.

² See *The Nation's Medical Research*. A report to the President by the President's Scientific Research Board, John R. Steelman, Chairman (vol. 5 of *Science and Public Policy*). Washington, D. C.: United States Government Printing Office, October 18, 1947. p. 8.

differs from applied research in that it deals with processes or techniques or products that have been discovered.

While these definitions seem somewhat technical to those of us who are not involved in research, the differentiation between basic research and what most of us call clinical research is quite clear and the distinction is valid and helpful. For practical purposes, we may consider that basic research involves the discovery of new facts or techniques, and clinical research, the application or the development of these facts and techniques to clinical problems.

The fact remains that in the total field of psychiatry, only an infinitesimal amount of effort is directed toward either basic or clinical research. As in the rest of medicine, "there is no over-all planning authority which has either the responsibility or the resources to insure the effective coördination of various research programs."¹ No one knows what any one else is doing except in occasional situations, and then chiefly by accident. Two of us in different parts of the country can be working on the same problem with no knowledge of each other's work.

Quite apart from the lack of coördination, the amount of research currently being carried out is extremely limited in proportion to our very pressing needs for it. These needs could be specified in various ways: One could cite the disturbing figures of the incidence of personality disorders from our experience in the last war, as indicated by rejections for the draft and the separations from the military service. Many other figures are easily available to indicate the extensive incidence of mental ill health in our populace, with resultant serious economic loss. There are many statistics on the extent and cost of our various social neuroses as exemplified in delinquency, crime, and divorce. We cannot hope to change the situation in many of these areas until we have further tested knowledge to apply to them.

Nearly ten years ago, The National Committee for Mental Hygiene attempted to survey, by the questionnaire method, the extent and type of research being carried on in psychiatry. In 1942, the same agency made a second attempt to determine the type and extent of research activities, facili-

¹ *Ibid.*, p. 118.

ties, interests, and interrelationships, as they existed under non-governmental auspices. At that time only 37 of 613 non-governmental institutions professed to be doing any research, and 17 of these presented small informal projects with no evidence of having an established research program. Only 26 of the 66 medical schools reported research activity related to psychiatry.¹

The President's Scientific Research Board did investigate medical research extensively, but only two very brief references are made to psychiatry in the 118-page report. One of these pointed out that "mental diseases and dental diseases which are widely prevalent in the general population and in the special population groups served by the Army, the Navy and the Veterans Administration, have received relatively little attention in the Federal Medical Research Programs."² A plea was made in the Steelman Report to balance research and direct an increased effort toward those illnesses, particularly mental illnesses, which are currently receiving insufficient attention, but which are recognized as major causes of disability.

The Research Committee of the Group for the Advancement of Psychiatry is working intensively at the present time on a survey of research programs in psychiatric hospitals and medical schools. Without funds to carry out a personal inspection, they have been unable to obtain more than impressions as conveyed by the written reports from these many sources. Such a detailed survey, based on first-hand investigation, is greatly to be desired. There is a remote chance that this same group will be commissioned by the research committee advising the National Mental Health Advisory Committee to carry on such a survey.

We do not have the exact information, but it is reasonable to assume that there are not a dozen full-time research workers in the field of psychiatry in the United States at the present time. This number would be slightly increased if we included those individuals who are working in clinical psychology. There is far too little research in the total field of medicine, and when the number of workers in psychiatry

¹ See *Research in Mental Hospitals*, Studies No. 1 and No. 2. New York: The National Committee for Mental Hygiene, 1938 and 1942.

² *The Nation's Medical Research*, *op. cit.*, p. 116.

is compared to the number of full-time research workers in other medical specialties, it is pathetically disproportionate.

Another guide in estimating the extent of psychiatric research is the amount of money that has been and is being invested in it from all sources. Our figures on this point are probably not very accurate, but certainly they indicate the general trend of current practice. When the National Mental Health Act was being considered, Senator Claude Pepper, summarizing the status of research in the field of mental illness, characterized it as being "utterly inadequate in view of the magnitude of the problem and its serious consequences to our society."¹

To quote Senator Pepper's report further, he stated, "The history of Public Health shows that more substantial sums for preventive work must be expended and a greater proportion of the greater expenditures for a particular disease must be allocated to research work if we are to make any real progress in this field. All public and private government agencies together are spending not more than 25¢ per year for research for each estimated case of mental illness, and only \$1.00 for each known case of total disability because of mental ill health, as compared, for example, with \$100 per case of poliomyelitis, a disease which is far less widespread."

Lawrence Kubie, in the hearings on this same congressional action, made the statement that "for every dollar that we spend for psychiatric research in this country, we spend \$2,500 in industrial research; for every dollar that we put into psychiatric research, we spend \$65 in other medical research."²

The President's Scientific Research Board reported that the best estimates indicate that \$110,000,000 was expended for medical research in 1947 and that to begin to meet the need, this should be increased to \$300,000,000. Unfortunately, the report did not attempt to break this sum down into various specialty areas, but did indicate clearly that expenditures for research into the problems of mental health have been far less than expenditures for research in other specialties in medicine and allied fields.

¹ See A Report to accompany HR 4512, 79th Congress Senate Calendar #1378, Report #1353, 16 May, 1946.

² See National Neuropsychiatric Institute at Hearing before a subcommittee on Education and Labor. United States Senate S 1160, March 6-8, 1946. p. 79.

Pertinent to this presentation at the Western State Psychiatric Institute, where research is a chief aim, are two significant facts. Of 28 state-university medical schools, eleven were allotted no funds for research in the general university budgets for the academic year, 1946-1947. Much of the research supported by state and local governments is statistical in method and is best classified as being background rather than basic research.

A further point regarding the situation in Pennsylvania. It puzzles us outsiders, who are concerned with psychiatric services as well as research, as to how effective use can be made of psychiatry's partner—social work—without a statewide merit system. It puzzles us even more why such a major state as Pennsylvania makes itself ineligible for the multiple benefits of the National Mental Health Act within the state system by the lack of such a basic provision for qualified social-service personnel.

No doubt the National Mental Health Act will be a great stimulus to research in psychiatry. For the first time there is a source of major financial support to stimulate and prime psychiatric research. Within the past year 39 grants have been made for research in some area of mental health.¹ These grants amounted to about \$385,500. It is hoped and planned that Congress will increase this amount considerably in the immediate years to come. It is well recognized by the members of the Advisory Council on Mental Health that, as the program develops, careful planning and coördination will be required. It is quite possible that consideration will be given to "target" research—that is, the assignment of certain types of research with the hope that operating organizations can find personnel and facilities for the work on specific projects. This same general plan is under serious consideration by the advisory committees in various specialties of the National Research Council. These committees have the responsibility of promoting specific pieces of research within the field of their specialty.

Why So Little Research?—Why has such a comparatively small amount of research been done in psychiatry? In the past, many factors have discouraged or limited the extent

¹ See *The National Mental Health Program, A Progress Report*, by R. H. Felix. Presented at the State and Territorial Health Officers Meeting, Washington, D. C., January 1, 1948.

of research in psychiatry and allied fields. The heavy demand for psychiatric services at present complicates the problem. One can hardly state that any one cause is more important or greater than another. Even a superficial analysis indicates that there have been and still are many obstacles to psychiatric research.

Economic causes, as previously mentioned, have been extremely important deterrents. There just has not been enough money available to support research. Many universities have had no money available for research of any type, and, if it has been available, it was the rare exception when it was devoted to psychiatry. Prior to the National Mental Health Act, there was little federal money for this purpose. Prior to 1947, most of the support for psychiatric research came from foundations or from private sources. According to the President's Scientific Research Board, 13 per cent of the money for all medical research came from foundations and about 9 per cent from voluntary associations, the latter being exemplified by the National Foundation for Infantile Paralysis.

One of our greatest and most pressing needs is for extensive basic research. This means full-time research workers. The economic problem is an extremely important one for the individual worker in this field. Most of the research positions that have existed have been less well paid than even ordinary teaching jobs. In fact, paradoxically, the research worker who labored in the laboratory was all too often eventually promoted to a higher-salaried teaching job which then took him out of research. This has come about chiefly because of our tendency to rate research below teaching in importance. Through such a practice we have given it this economic handicap.

Furthermore, the contrast between the financial remuneration of research and that of the private practice of psychiatry (or any other medical specialty) has discouraged all but the most stalwart, self-sacrificing individuals from considering even momentarily the possibility of going into full-time research work.

The greatest obstacle, then, is that as yet we are not willing or able to pay the worker his due. We have been giving

only lip service to the concept of placing a high priority on research.

A second great obstacle has been—and is—the lack of a numerically adequate and capable trained personnel. It takes an individual with a specific personality make-up to become a successful worker in basic research. The desirable qualities have been well described by Cannon.¹ He listed the more important characteristics of the investigator as imaginative insight, keen powers of observation, patience, critical judgment, thorough honesty, retentive memory, good health, and generosity.

He pointed out very clearly, however, that many individuals who have a number of these qualities lack others. Some cannot get along with people. Some display an attitude of superiority. Some are indolent. Some are secretive. All of these traits result in failure. Long experience in research has shown that comparatively few people are capable of becoming outstanding research workers.

Theoretically, we might expect such workers to grow up in medical schools. As a matter of fact, our few full-time researchers who have contributed to medicine have usually come from that source. However, their rarity is recognized by the President's Scientific Research Board in the conclusion that "discovery of one first-class investigator in every medical school each year would more than repay any expenditure necessary to provide opportunities and support for medical students who show aptitude for research."² The obvious implication of such a statement is that very few individuals show such an aptitude, and that this national group of scientists would be gratified if 77 new workers could be developed each year. In so far as psychiatry is concerned, there is a still greater disparity between the number of workers available and the seriousness of the morbidity problem than in any other field of medicine.³

Another major handicap of psychiatric research has been the very nature of the subject. Psychiatry must, of neces-

¹ See *The Way of an Investigator; A Scientist's Experience in Medical Research*, by W. B. Cannon. New York: W. W. Norton and Company, 1945.

² *Nation's Medical Research*, op. cit., p. 31.

³ See *American Medical Research, Past and Present*, by Richard H. Shryock. New York: The Commonwealth Fund, 1947. p. 232.

sity, be grounded in psychology, and in the physical sciences of anatomy, chemistry, and physiology. No one, however, denies the fact that a great deal of the effort that has been spent in research in these basic sciences has been relatively sterile in throwing light upon psychiatric problems. Furthermore, we have not as yet developed a generally accepted methodology in many of the problems of clinical psychiatry that can be regarded as basic research. To be sure, a great deal of progress has been made through the remarkable developments in the chemical and pathological approaches to mental illness. Unfortunately, however, there has been a very great gap between these approaches and the practice of clinical psychiatry.

This has been well expressed by Dr. Edward Strecker, who has stated that "unaided and undirected, the exact scientist cannot save mankind from destruction, however great his achievements; and there have been none greater. I think of the reflections of the philosopher who said that the airplane was made by supermen, but had fallen into the hands of the apes. The exact sciences need less exact psychiatry. Pooling our effort, we can save man from destroying himself."¹

Much of the practice of psychiatry is an art. On the other hand, there is no conflict between the use of tested knowledge and the art of healing. So long as we deal with people, both will be required. Many aspects of psychiatric practice as it applies to interpersonal relationships, many of our treatment methods, and even many of our results, cannot yet be successfully subjected to statistical validation. This is due in part to our varying concepts of mental illness, and in part to the fact that no method has as yet been devised to standardize the measurement of emotional or intellectual processes and many other observed phenomena. We are making a little headway in this direction, particularly through the contributions of the clinical psychologists. This deficiency, however, has been a serious impediment in the development of basic research in psychiatry.

Still another obstacle to the development of psychiatric research is the very practical problem created by the terrific

¹See "Psychobiology in Psychiatric Research," by Edward A. Strecker, in *Psychiatric Research*. Cambridge, Massachusetts: Harvard University Press, 1947. pp. 1-13.

demand for psychiatrists in clinical work at the present time. This is related to the enormous need and demand for psychiatric treatment, to the potential economic remuneration in the practice of psychiatry, and to the tempo of life that we clinicians currently lead. It is rare that a practicing physician can carry on applied or developmental research activities in addition to a crowded clinical schedule. If he does, he must use hours that are needed for rest, diversion, and relaxation by himself or with his family and friends. Too often little or no time is allowed for these purposes. The psychiatrist, the clinical psychologist, or the social worker already has too few moments of leisure.

My associate, Dr. David Rapaport, has made a somewhat startling comment on this problem. He has expressed the belief that if we were to give research a high priority, many psychiatrists and clinical psychologists would have to neglect the current demands for psychiatric diagnosis and treatment. We should develop a system that prevents the researcher from being lured away from research into clinical activity merely because of the demand or even because of the greater economic security that clinical practice presents.¹

One final factor that limits research in psychiatry is our failure to train individuals in research methods. Already our training course in psychiatry is extremely long, perhaps longer than that in any other specialty within medicine. In the already full medical-school curriculum, no specific training in research methods is given. Along with the teaching of basic science should go at least some presentation of the techniques used in the search for background knowledge. No medical student should be graduated without learning about the brilliant discoveries that are the basis of modern medicine. Nor should his course and medical-school experience come to an end without his participating in some type of research project.

It has been my personal experience that many graduate students and even psychiatric residents have an extremely limited knowledge even of how to use a library. It is probably accurate to say that the majority of our resident training programs in all fields of medicine fail to include any

¹ See "The Future of Research in Clinical Psychology and Psychiatry," by David Rapaport. *American Psychologist*, vol. 2, pp. 167-72, May, 1947.

introduction of the student to the field of research, either basic, applied, or developmental.

Much of the immediately foregoing discussion has applied to the full-time research worker who so often devotes himself to basic research. In some degree, however, these same obstacles are deterrents to the clinical research that many of us pursue in the course of our daily activities of seeing and treating patients. Because of our lack of training and orientation, far too few clinicians are capable of carrying out clinical research projects. They do not know how to find out what others have previously studied or discovered. They do not know how to set forth the problem, how to proceed with the investigation, how to summarize findings and arrive at valid conclusions. A minority know how to go about writing up their studies for publication so that other interested people can learn from it.

It is to be hoped that in the training of our residents, we will orient them in research—to procedures, to problems, and specially to feeling a moral obligation to carry on continuously research projects. The fact that one is not able to undertake or capable of carrying on basic research should in no way excuse him from contributing to the progress of medical science. Medical education and residency training in the field of psychiatry should in all instances be challenged to present this responsibility. This applies also to graduate training in the fields associated with psychiatry.

There are, however, some other points that I should like to make about research, particularly as it applies to psychiatry. While these remarks may be concerned chiefly with the full-time research worker, they may also be applied to the clinician and to our ancillary associates who can contribute only a very limited amount of effort and time to research work.

The Support of Research.—Related to the obstacles confronting research in psychiatry—or, in fact, in any other branch of medicine—is our current practice with regard to stimulating and managing research. In general there have been three methods of supporting research. The method used most extensively in industry, particularly during the period of the war, was to assign research projects, with ample funds for its prosecution, to an individual or to a group. They were

assigned to seek the solution of some problem or to meet a particular need, rather than to follow the lead of scientific curiosity. Such support of research was justified, and with unlimited economic backing, workers were able to accomplish the apparently impossible in relatively short periods of time. Perhaps the outstanding example of this was the atomic bomb, concerning which it has been conservatively estimated that the speed of the investigation and the production of the end result condensed the progress of fifty years into three. Much of the research during the war period—particularly as applied to industry and in some degree to medicine—was carried on in this way. There is legitimate basis, however, for questioning whether this is research at its best.

A second method of supporting research—and one widely used under normal circumstances—is that some individual or group develops an idea or plan and makes application to some disbursing agency—a foundation, the government, a state, or a university—for funds to carry out the proposed research. Such a method has the questionable advantage that the researcher or his group must formulate their plans and set forth the program of investigation in detail. It also permits the limiting of a commitment as to the extent of the program on the part both of the grantor and of the grantee. It has the advantage that small amounts of money can be obtained for short-time work that would not be available to support a full-time worker over a long period.

On the other hand, there are many disadvantages in the system of making individual grants for specific projects. Very often there are no funds for the exploratory or background research. The researcher must commit himself as to his plans, even though many of these must be speculative and uncertain. If he initiates his program and then finds that he must change it, he can do so only after obtaining permission from the grantor of his finances. An even greater handicap is the fact that most grants are made for a period of one fiscal year and rarely does a research program adequately fit into the fiscal year. Always hanging over the researcher is the specter that possibly his grantor may not continue his support for another year.

This system, therefore, provides no tenure for the worker. We can hardly expect scientific investigation to flourish

when it must depend upon year-to-year grants, which in turn inevitably depend upon how convincingly some one is able to present his particular project to the grantor, or how free money may be at the time of the request. There are too many competing opportunities that do not penalize the individual with insecurity of tenure as does a research program based on yearly grants.

Fortunately, there is a third method, initiated by the Rockefeller Foundation as long as fifteen years ago, which does provide a sense of security in the form of tenure. The Rockefeller Foundation has given subsidies to research workers instead of giving funds for specific projects. In general, this plan is being adopted by other foundations. Such a grant, given for a period of years, permits the researcher to follow his own inclinations and to change the course of his program as he sees fit. Only as all research workers attain such security can they be expected to produce the most effective results.

In all three of these methods, however, the research worker is confronted with continuous temptation and with continuous pressure. That is particularly true in the field of psychiatry. I am reasonably sure that nearly every full-time research person in psychiatry to-day could increase his personal income from 50 to 100 per cent or more, were he to desert research and go into one of the many opportunities for clinical work.

Unless doing research on a full-time basis, however, under current pressures it is extremely difficult for the individual to find and to maintain a sense of leisure that permits him to plan, to investigate, and to think. Even so, it is extremely difficult to protect the worker so that he may have this privilege. Particularly if he is connected with any type of medical group involved in teaching and practice, is he continuously placed under pressure to participate in one or the other of these activities in addition to carrying on his research. It should be our aim in psychiatry to increase the number of workers in this field and to husband their energy for their studies in every way we can.

Not unrelated to this problem, however, is the dilemma confronting those of us in clinical work who long for and continuously strive to find time to devote to clinical research,

either applied or developmental. As was indicated before, those of us who try to participate in such work must do so on "our own time." Many of us feel our obligation in this direction, but are confronted with the continuous and increasing pressure of demands for treating patients and meeting the needs in teaching and training, and of continuous appeals from the public for more helpful information about psychiatry.

I have not mentioned the need for coöperative research between psychiatry and its allied fields and all of the other social sciences. Never before has it been so essential to take cognizance of environmental problems, of the social neuroses, of the sick world. So far psychiatry has not been ready to contribute much toward the solution of these social ills. Relatively few coöperative efforts have been made between psychiatry and the social sciences and this, too, is a pressing obligation for us when planning our research activities.

Up to this point, my remarks have dealt with the general problems of research in psychiatry. In closing, I want to speak briefly about the local situation. Through the great vision of some of our psychiatric confrères, and, in particular, of Dr. William C. Sandy, in coöperation with some of the administrators of the commonwealth of Pennsylvania, this remarkable institution—the Western State Psychiatric Institute and Clinic—was built. The chief purposes of the institute, as conceived by those in charge, were those of research and training, and it was hoped that the institute would be the center of inspiration for psychiatry and allied disciplines for the state of Pennsylvania.

From various sources, I have attempted to find out some facts about the expenditures for health in Pennsylvania. The department of welfare has an annual budget of \$88,000,000 for the general area of health, which does not include \$10,000,000 expended by the board of health. Of the total sum, \$22,000,000 is allotted for the Pennsylvania hospital system. Of that amount, \$750,000 is allowed as the budget of the Western State Psychiatric Institute. Unfortunately there is no breakdown in the budget to indicate a specific sum for research, and this situation applies even to the insti-

tute, although by law one of its chief functions is designated as research.

By a rather liberal estimate of expenditures in all departments, the institute spends the total of about \$36,000 a year on research, augmented by grants of an additional \$12,000 from out-of-state sources. The capital investment for research is roughly estimated at about another \$36,000. The funds, then, for an institution conceived of as a leader in research, and legally chartered to carry it out, allow only about 5 per cent of its budget for this purpose. If we look a little further, we find that probably none of the state hospitals can invest more than 1 per cent of their budgets in research.

Despite this minimal fund of money, much has been done. But much more can and, in fact, must be done. The visions of the founders have hardly started toward realization. Obviously the institute needs a greatly augmented professional staff of teachers, with outstanding ability. It needs many more full-time research workers. Basic to the realization of its purposes is a much augmented budget. In our present state of desperate need for tested knowledge, it would seem that a sum at least 5 per cent of the state's expenditures for health should be spent in research. Were we to compute this on the current budget of the department of welfare, it would amount to \$4,400,000; the share for mental illness on the basis of state-hospital expenditures would amount to \$1,100,000 a year. What are we spending? Less than \$50,000!

In addition to these needs for men and money, the institute must be capable of giving inspirational leadership, so that it may fulfill its responsibility to serve as a beacon in the study of mental health throughout the entire commonwealth of Pennsylvania, and far beyond its confines. Many of us confidently believe it can do this. However, it will require not only the necessary professional and financial help, but a clear understanding of the need on the part of the public and the public servants, the legislators.

To summarize, the future of psychiatric research depends upon many factors, some of which I have attempted to headline. However, I have not touched upon the necessary coördination between psychiatry, clinical psychology, psychiatric

social work, and psychiatric nursing. We have had some hopeful, promising experiences in working together. Unfortunately, so far much of this has been lip service, and all of us have continued in our own grooves, too often ignoring the necessary integration that must take place.

Psychiatry as a specialty of medicine has an enormous amount of information to contribute to the general practice of medicine. Before it can fully meet the opportunity, however, it needs far more tested knowledge, which can come only through research. In addition, we must press for the institution of controlled and evaluated applications of psychiatric principles to many social problems.

We must reorient ourselves toward the necessity for research in psychiatry and the provision of optimum conditions for it. If we are to begin to meet the current needs for psychiatric treatment, in addition to the training of personnel and the education of the public about mental health, we must have a greatly increased fund of tested knowledge that can be obtained only through research. As the public, including voters and both federal and state administrators, come to understand more clearly that our urgent problems are theirs also, we may hope for their increased support.

EXPERIMENTAL METHODS IN PSYCHOPATHOLOGY *

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HOW can or how should one design research in the field of mental hygiene, or more specifically in that of psychopathology? Before discussing this major question, there is some point in considering research in general, together with the men who do research. Research is undertaken to answer questions. Sometimes the questions are real, sometimes not. Some one was curious and sought an answer. Sometimes the answer obtained ends the question. But essentially research has been undertaken because questions and problems exist and some one had a notion of how answers might be obtained. To-day it is customary to submit urgent questions to research specialists and to encourage them to try to find solutions, particularly when there seems no possible solution.

The best research men have an exaggerated sense of curiosity, an enormous amount of skepticism, and the hopefulness of confirmed gamblers. They are obsessed to know the reasons why. They want to know the answers. They are profoundly skeptical of the usual explanations and even of the finality of the answers that they themselves secure. They are hopeful that the next experiment will give an answer, even though the previous 999 did not. Most human beings are curious about the world around them, a good many people are skeptical, and there are plenty of gamblers. Good research men have a proper balance between these traits. In addition, they have learned, often through bitter experience, how to ask questions to which it may be possible to secure answers.

What is a good research question? One that will lead to an active search for a meaningful and useful answer. That much is obvious. Further defining of a good question is difficult. Questions should be related to real problems and

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not to incorrectly related events or haphazard formulations. It is often very difficult to distinguish between real problems and pseudo-problems. I take it that a real problem is one that is somehow interrelated with an essentially unifiable set of phenomena that belong together in some fashion. If the question is based on such interrelated material, there is some chance of dealing with it in a logical fashion. If it turns out to be a mixture of two or three quite different kinds of material, then the question breaks down and no single answer can be found, nor is it often possible to find a set of answers. The interrelated phenomena must be such that when they are mentally surveyed, there are one or more clues or entries through which one may attempt an experimental solution. There are any number of real problems that at present offer a smooth face of insuperable difficulty, with no clue as to a possible approach.

Confronted by a real problem or question, how may one design a research approach? It goes without saying that the usual proclamations and authoritative dicta will be by-passed. If proclamation solves the problem, there is no need for experiment. Experiments start when proclamation has failed. As a rule it is more profitable to turn at this point to the finding of a competent research man. When he is found, he should carry out the design of the experiment.

But how does one secure the proper person to do the research that is to answer the problem? It is apparent that not every one is capable of doing research and also that not every one who has had research training is an effective researcher. Investigators are of many descriptions and work in a variety of ways. The usual pattern is something as follows:

The researcher surveys the problem. This usually means that he turns to the library and makes use of the highly specialized abstract systems and cross-reference systems. Such a survey may take some time, but it accomplishes several aims. What is known and what has been tried previously become clear. Methods of approach and points of attack are evident. And it should become apparent whether a real problem exists or not.

We will assume that the investigator is fully competent in the matters of technical skills, laboratory routines, mathe-

matical procedures, tool designing, and so on. These points are usually taken care of in graduate-school training and in the apprenticeship.

The experiment is then undertaken. It is carried through to a successful conclusion. Now comes a new problem. The problem and its solution, the question and the answer, must be reported in such fashion that any intelligent person can understand the report. It is at this point that many otherwise excellent and competent investigators falter and do slipshod work. If the problem was worth doing, it was worth reporting. The composition of a scientific report is not easy nor can it be trusted to unskilled hands. I believe more waste results from inadequate and inaccurate scientific reporting than from any other procedure of the research project.

Finally the project is complete, the answers are clear. But now in place of one question, there are ten or more that must be answered. The answering of these ever-pyramiding problems we call scientific progress.

Having set up in such a discursive fashion certain of my not too original ideas concerning the nature of research and researchers, it is time that I turn to the essence of what I have to say concerning the application of the experimental method.

Let me take up some of the problems that to-day are important in psychopathology. Consider anxiety.

Anxiety is both a very old and a very new problem. It is old in that the human being is a fearful animal who has always sought his own self-preservation. To-day it is a commonplace to hear that our modern culture has exaggerated rather than minimized individual anxieties. Even in our relatively safe and isolated America, where hunger is rare, oppression most limited, and general freedom and liberty greater than ever before in man's history, psychiatrists and clinical psychologists are incapable of treating all of the anxious persons who appeal for help. Individuals and organizations are constantly pressing for changes in laws, for reëducation, for changes in social consciousness, so that the mental hygiene of the nation may be improved. And as each change, each law, each new progressive educational scheme comes into being, there seem to be more, not fewer, anxious, fear-ridden persons. If I may paraphrase Shake-

speare, I should say that the fault, dear reformer, lies not in society, but in ourselves, that we are anxious. The question is why do certain persons suffer from uncontrolled and uncontrollable anxiety?

We should distinguish between behavior that is thought of as arising from some central event or state and the central state itself. The distinction between anxiety and anxious behavior must be constantly kept in mind. The central state we call anxiety is a construct or a postulate and not an empirical fact. Anxiety is a hypothetical entity that "explains" certain kinds of behavior. Anxiety goes by many names—fear, worry, guilt, apprehensiveness, dread, terror, panic, nervousness, compulsiveness, obsession; all terms used to designate a common central idea or construct.

Anxiety appears suddenly and unannounced—it comes gradually and with ample forewarning. It is appropriate—it is inappropriate. It is understood by the sufferer—it is incomprehensible. It grades from a mild worry to a persistent, completely disabling panic. It feels like a fear or a worry—it has a unique quality of feeling. It occurs when one is in good health and spirits—it happens when one is sick and depressed. One quality is common—it is beyond the ordinary bounds of self-control.

It is more apt to occur in some persons than in others. In some familial or genetic groupings, it is rather frequent, while it is rare or absent in others. Its form of expression is usually in accord with the educational or intellectual status of the person. It can be elicited in many people by closed, locked places, by hampering of freedom, by social disapproval, by mild wasting illnesses, by prolonged danger or physical stress. It can frequently be alleviated or cured by recounting one's troubles to some one else, by guidance and suggestion, by a better-balanced diet, by removal from danger or stress, or by social approval.

It has no anatomical or physiological basis as such, so far as we know. It is associated with bodily and visceral responses, particularly those of the autonomic and endocrine systems. Any major interference with cardiovascular activity, such as angina, or intravenous injection of adrenalin or metrazol, is experienced as an acute anxiety or panic state. It can be brought about by certain kinds of vitamin depriva-

tion, and it can be alleviated with appropriate vitamin feeding where there was a deprivation.

This is a sample of the knowledge that is available about anxiety and anxious behavior. We are now in a position to ask certain questions that might be profitably investigated by the application of the experimental method.

A first question is this: Is anxious behavior of one sort? Or is it the reflection of innumerable causes? If of one common origin—as, for example, pellagra, depending on niacin deficiency—then one design of experiment will be set up. If anxiety is of multiple etiology, as is rheumatism or headache, other approaches will be made. The best guess is that anxiety is of multiple etiology. Perhaps it is dependent on a limited number of factors, but certainly on more than one or two. Having made this assumption, we can ask another series of questions.

Is there a physical constitution, a somatotype, more susceptible to this or that form of anxious behavior? Is there a personality type or structure more susceptible to this or that form of anxious behavior? If anxious behaviors occur more frequently in certain somatypes or personality structures, do they differ in kind or in degree?

What are the similarities and differences between the conditioned neurotic anxieties and “spontaneous” anxieties? The method of conditioning has shown very clearly that it is possible to establish a variety of anxious behaviors. There is, as yet, no evidence that this behavior is identical with, similar to, or distinct from other forms of anxious behavior. Is anxiety a sub-acute persistent fear set up by one situation, then detached from it, and anchored only in an apprehension of the future? What relation exists between one’s comprehension of the future and anxiety? Are those who are foresighted and farsighted and playful more or less apt to suffer from anxiety?

Why should electric-convulsive therapy terminate anxiety? Why should prefrontal lobotomy terminate anxious states? How and under what circumstances does anxiety recur after electric-convulsive therapy? What differences exist between the anxiety or anxious behavior shown by an individual before and after lobotomy?

It is my belief that anxiety is an individual matter and that it can be understood only through study of the individual. Therefore, I see little profit in what one might call the sociological, anthropological, or cultural approach to the problems of anxiety.

Another point at which the experimental method can profitably be applied to problems of psychopathology is in relation to the shock therapies. What do we know about the effects of electric-convulsive therapy on psychopathological states? We know that there is no loss in intelligence or intellectual functions or in the ability to learn. So far as we know, the only psychological functions changed are memory and affect. Memory is usually temporarily disturbed after electric-shock therapy. Zubin and others have shown that the memory loss is spotty and localized, including specific memories rather than a generalized loss. Some of these losses are regained rather rapidly and some persist six months or more. Which memories will be lost, seems quite unpredictable. The loss is quite as apt to include unimportant, as well as important, memory traces. The loss may involve either affective or non-affective memories. The recovery likewise may bring back important or unimportant, affective or non-affective material. The disturbance in the mnemonic function is an interesting sort of mental confusion and one that deserves greater study than has been given it so far.

It seems more probable that the real change brought about by shock therapy is one of affect or emotional reactivity. The acute anxiety, the painful depression, the press of maniacal elation are reduced and this reduction is directly related to the patient's recovery. Whether this change in "emotional pressure" is part of the mental reorganization brought about together with the general confusion and memory disturbances, or whether the affective loss is specific, is unknown. Most of the evidence would lead one to believe that there is a rather marked and definite loss of affect *per se*. It is not a total loss, of course, since the patient may be quite emotional during or after the course of treatments, but the overwhelming nature of the emotional experience is no longer central in the mental life of the patient.

Psychologists are at a disadvantage when they are called upon to measure or to investigate affective changes. There are no satisfactory instruments available. The best we can do is through an interview or a questionnaire. Emotional changes are not clarified or explained in any very satisfactory way by interviews or questionnaires. At this point the necessity for certain basic scientific research comes to the foreground. There is a real need for the development of new or better methods for measurement or indication of affective changes. I must admit that I have labored long in such an endeavor and without success.

The recent rapid development of prefrontal lobotomy or psycho-surgery, together with its spectacular results, leads us into another possible application of the experimental method in psychopathology.

Twenty to 30 per cent of hopeless, deteriorated back-ward mental patients make great mental recovery after the fiber tracts of the white matter connecting the frontal lobes and the thalamic nuclei have been severed. As with electric-convulsive therapy, there is little or no loss in intellectual function. Numerous investigators have studied the puzzling and baffling change in mental life shown by the lobotomized patients. They lose a year or so of mental age on the Porteus-maze test after operation, but regain that loss if they make a social recovery. There is a decrease in visual critical flicker fusion threshold. There are individual losses and gains, some of which may be quite striking in different psychological-test performances, but nothing that is constant or too revealing.

Freeman and Watts characterize the change brought about by successful lobotomy as a loss in painful self-consciousness and a bleaching of emotion. The patient is no longer pre-occupied by his own self-conscious and self-referred anxieties and fears. Those who recover seem at peace with the world—too much so, in fact. They are somewhat direct and childish in emotional responses and are inclined to be careless about the future. The family says that they are placid rather than spirited.

There is need for a careful and quantitative investigation of the personality alterations of a group of patients studied before, and followed for several years after, lobotomy. We

need to know what patients should be subjected to lobotomy, and when. Is the method only one of last resort, or should it be used early in the course of certain mental illnesses in order to bring about best results? What psychological-test-performance pictures indicate a favorable result and what is the test picture when a favorable result occurs? I may digress, at this point, on a technical matter.

The idea that the abstract attitude, the ability to generalize, is dependent on the functional integrity of the frontal lobes has been stressed by Goldstein. Many psychologists use the Goldstein-Scheerer tests to assess organic brain involvement in mental cases. Psychiatrists often base the therapeutic approach on this test report. Most peculiarly, lobotomy does not regularly affect the abstract attitude or the performance on one or another variety of sorting test. That the anatomical and functional integrity of the frontal lobes has been altered, is evident. That some patients are in no way changed in abstract attitude or ability to generalize, has been reported by several investigators. The point deserves specific attention.

To digress still further, it seems to me that a great many psychological tests that we have attempted to apply to mental patients have been and remain unnecessarily restricted in an attempt to gain objectivity. The interview techniques that Kinsey and his associates have evolved and that they have used so brilliantly in the study of the sex behavior of the American population might very well be taken over and applied direct to many of the problems in psychopathology. I do not mean that the interview would have to involve sex life. Far from it. These methods of interview, together with the coded, immediate recording of responses, could be very well adapted to a wide variety of psychological-test procedures. A great deal more information could be obtained in a much more satisfactory fashion from patients if psychologists and psychiatrists were trained to interview and to record in such a consistent fashion.

There are, of course, in any psychiatric hospital thousands of case histories that record interviews with patients. The trouble with these histories is that they afford no very satisfactory basis for real comparison of one patient with the next, since individual examiners stress different points and are not

always too accurate in their reporting. The collection of a systematic body of knowledge and the subjecting of this knowledge to ordinary scientific evaluation would do a great deal to reorient our thinking and to reformulate incorrect and questionable problems that actually hinder knowledge.

To return to the experimental method in psychopathology, let us consider the question of schizophrenia. I am impressed with the genetic investigations of Kallmann and would agree that schizophrenia occurs only in individuals who are constitutionally predisposed—that is to say, the genetic background of any particular individual either permits or does not permit the development of a schizophrenic psychosis in that person. To the smaller fraction of the population who are so predisposed, we must give close attention. The much larger number who are not predisposed need not concern us.

To those individuals whose genetic constitution makes it possible for them to acquire a schizophrenic psychosis, we can address our experimental investigations. We will have to find out what such individuals have in common in addition to their predisposition. We should know whether their physical constitution or their somatotype is one that somehow differentiates them from the individual who cannot acquire schizophrenia. We should find out whether there is a pre-psychotic schizophrenic personality that goes with some specific physical constitution or somatotype. If there exists either a unique somatotype or a particular type of personality, it would be possible to construct psychological devices or examinations that should give some basis for saying whether or not a particular person has the potentiality of developing the disease.

This prediction is not a new idea. Various investigators during the past twenty-five years have made good surveys of the pre-psychotic personalities of mental patients. In general it has been found that the pre-psychotic personality of dementia-præcox patients is one of introversion and shyness, of schizoid ways of thinking, with a tendency to be retarded in psychosexual development. Unfortunately for the investigators, not more than 50 or 60 per cent of the patients who do develop schizophrenia could be so characterized before the onset of their psychosis.

The pre-psychotic personality is evidently differential for

a portion of the predisposed, but not for all. It seems entirely feasible that one might sharpen up such a personality investigation and apply it to several thousand adolescents. The results could be filed away while one waits for the inevitable. During the succeeding fifteen years, 1 or 2 per cent of the group would develop a schizophrenic episode of longer or shorter duration. One could then go back to the records and find which personality traits were differentially related to the development of the schizophrenic psychosis.

Even at present it would be possible to collect material of this type in a fairly systematic fashion because of the large number of mental tests and personality studies that have been done during the past fifteen years with junior and senior high-school students. Such an investigation would involve going to the schools that diagnosed schizophrenic patients had attended during their adolescence to find out what the actual performance and behavior of these individuals had been during their pre-psychotic days. I am confident that such a survey made of several thousand cases in which considerable data were located and made available would be most illuminating and would give us a better basis for preventive work in mental hygiene than we have available at present.

If schizophrenia is a disease that develops only in those who are constitutionally predisposed, the question arises as to whether it is precipitated or whether it appears as a natural consequence of growth and maturation. If it is one of maturation, the problem then will rest with the biological scientist for further elucidation. If, on the other hand, this is a disease that is precipitated, then the psychologist, the sociologist, or the educator should be able to point out the particular or peculiar circumstances that give rise to the disease in those who acquire it.

Assuming that it is a precipitated disease and that the psychologist could contribute, how should he go about his particular problem? The following questions seem relevant to me: Does stress break down a schizoid personality into a schizophrenic psychosis? If so, what conditions, what stresses, at what ages, are most likely to precipitate the event? What mental mechanisms act to facilitate or to hinder the precipitation of a schizophrenic psychosis? How does

the schizophrenic patient who recovers reorganize his mental life? What changes in attitude, motives, and beliefs take place during recovery and which of these changes are related to the recovery?

What is the significance of hallucinations at the onset and during the schizophrenic psychosis? Hallucination is certainly one of the central symptoms in the disease and one that is of particular significance and distress to the patient himself. One would like to know whether these hallucinations are projections of unconscious wishes or repressed desires, or are they nothing more than the misinterpretation of stimuli occurring around the patient when he is preoccupied with his own thoughts or anxieties? To what extent are the hallucinations that may be brought about by the direct stimulation of the parietal and temporal lobes equivalent to the hallucinations experienced by the mental patient? Is it possible to set up artificial hallucinations in the patient, and if that is impossible, what are the criteria by which the patient distinguishes between the artificial material and the subjectively experienced hallucinatory event?

When and at what psychological point, in the passage through and out of the acute phase of the schizophrenic psychosis, should psychotherapy or psychological guidance be used? What particular sort of therapy or guidance is most effective? Is there any relationship between the pre-psychotic personality structure of the patient and the form of therapy that is most effective?

One could go on with a list of questions of this sort, but it seems to me that if one takes a consistent view, then it is possible to ask meaningful questions to which possible research can be directed, and if such research is undertaken—as it probably will be in the near future—that our information concerning the disease process and the mental-hygiene methods that may be taken in the prevention of schizophrenia will be more effective than they have been in the past.

In conclusion let me offer these observations:

1. Research has brought great dividends to mental hygiene during the past twenty-five years. Electroencephalograms, electro-convulsive therapy, psycho-surgery, insulin-shock therapy, dilantin, diagnostic psychological tests and so on,

have made the picture of mental disease and mental health much more hopeful than ever before in history.

2. The experimental method has an honorable history in psychopathology. It should be used more extensively. We are much more apt to aid than to injure the patient by using well-conceived experimental techniques. Careful, wise consideration must at all times be employed, but just as experimental surgery is drastic, but carries forward the conquest of physical disease, so should experiments in psychopathology carry forward the conquest of mental disease.

3. Experimental studies in psychopathology can and should do much in the near future to make rational the now irrational methods of shock therapy and psycho-surgery.

4. In the last analysis, progress depends on the gains made in pure science. Mental hygiene and psychopathology should contribute to the cause of pure science much more than they have in the past. There is need to look above the terrible immediate urgency of the problems of neuroses and psychoses to the forwarding of basic knowledge, so that new and, to the practical mind, undreamed of methods may be made available for future progress.

BASIC CONCEPTIONS IN SOCIAL- WORK RESEARCH *

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WHEN I was first asked to prepare a paper on research in social work, I thought that I should start with the fact that social workers apparently find it difficult to formulate questions for research in terms that point the way to securing answers. They are likely to take some general topic—the unmarried mother, transference in case-work, intake—and then let their eyes rove through case records, casting about for any data that seem pertinent to the topic or, more important, “interesting.” The research report consists, then, largely of a compilation of these rather random observations.

There are many things wrong with such research. From lack of precision in the original question comes carelessness in the selection of cases—interest rather than representativeness being stressed—and the making of unwarranted generalizations. Then, too, the research is likely to stray out of social work and into sociology, psychiatry, administrative statistics, leaving the reader who is in search of new knowledge in his own professional field feeling rather thwarted.

Thinking along these lines, I began to wonder whether the difficulty does not lie much farther back than in research techniques—whether we must not start our analysis with a consideration of the function of research in a profession’s activities.

The function of research in a profession can be no better indicated, it seems to me, than in Whitehead’s definition of a profession itself. This definition is so pertinent to the basic issues in social work that I hope you will pardon a rather lengthy quotation. “A profession,” say Whitehead in *Adventures of Ideas*, “is an avocation whose activities are subjected to theoretical analysis and are modified by

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theoretical conclusions derived from that analysis. This analysis has regard to the purposes of the avocation and to the adaptation of the activities for the attainment of those purposes. Such criticism must be founded upon some understanding of the nature of the things involved in those activities, so that the results of action can be foreseen. This foresight based upon theory, and theory based upon understanding of the nature of things are essential to a profession. The antithesis to a profession is an avocation based upon customary activities and modified by the trial and error of individual practice. Such an avocation is a craft."

Now, without dwelling on the embarrassing question of whether social work is a profession or a craft, I think this definition gives us a very good lead as to what is lacking in social-work research and why that research is so difficult. In the well-established professions, there is no question as to what are the "things involved in its activities" or what the "purposes of the avocation" are. Consequently, research is clearly directed to finding out more about the nature of the pertinent phenomena (the anatomy and the physiology of the human body, for example) and to determining whether the profession's activities fulfill its purposes with respect to those phenomena (to continue the example, the alleviation of the ills to which that body is subject). Just the opposite is true of social work. We are extremely far from agreeing on what the purposes of the profession are, what its proper activities, and what the phenomena to which its activities are addressed. Accordingly, each investigator—instead of having the choice of hundreds of well-defined problems with which to start his study—has to go back to first principles and try to determine from them just what it is that we do not know or that we take for granted.

This ability to question the well-established or the customary—to maintain the man-from-Mars attitude toward matters that others take for granted—is a rather unusual intellectual trait and one that may even be rather disliked in an avocation that does not encourage its use. While it is a trait needed to some degree by all research workers, in the well-developed professions it need be possessed to a high degree only by the leaders, who will set the broad outlines of the research to which the many can address their

efforts. In social work, on the contrary, most research workers have to possess it, for, in order to work at all, they must determine for themselves what the profession aims to accomplish by its activities and to what phenomena those activities are addressed. Only after those questions are settled in a particular sphere, can they undertake research to determine whether the activities accomplish their purposes or what is the nature of the phenomena with which they deal.

To give you an example, there is at present considerable interest in the question whether family case-work is effective. Effective for what? Effective with what? What is it that the family case-worker is trying to accomplish? What is the real nature of the difficulties with which she is working? The trite answer, "Improving social relationships," proves almost valueless when actual cases are examined, if only because we are not at all clear as to what a social relationship is and what interferes with its functioning. Perhaps we shall find that we can no more ask whether case-work is effective than we can ask whether medicine is effective. What kind of medical activity directed toward what kind of phenomenon, must surely be specified before the question has any meaning.

To suggest that social-work research must start from an explicit and theoretically grounded proposition regarding the purpose of the profession and the phenomena to which its activities are addressed may seem highly academic. Comparison with the research situation in other fields suggests, however, that one of the chief reasons why research in social work is so difficult lies in the lack of a systematized body of knowledge that is peculiarly the profession's own. I say "systematized" advisedly. Certainly there is much that social workers know that is unknown to others, but this knowledge is largely uncoordinated and its principles and hypotheses are only vaguely stated. Consequently, each research worker has to struggle to make clear what the points at issue are before he can proceed to the technical research task of determining which of them is correct. Compare this with the situation in the scientifically advanced professions. In them many questions to be answered by research stand ready formulated; every practitioner knows some of them, and the major work of the research laboratories is concen-

trated on devising means of checking on hypotheses that flow logically from the ever-growing body of related concepts and principles that constitute the profession's field of knowledge.

On the research worker in social work a much greater task is imposed. Instead of asking, "Is this that we believe really true?" or, "Is this hunch a good one?" he must usually start with "What is it that we believe to be true and what are our reasons for thinking so?" Hence, the research point of view is rarer among social workers than among members of other professions, not because social workers are less bright, but because the state of development of the profession is such that it takes a much greater intellectual effort to specify what should be studied. It follows, then, that a major task in research in social work is to collect the current concepts and principles and to make their theoretical background and relationships clear. Such research would no sooner be under way than a multitude of questions would come to light that could form the basis for many smaller and more detailed investigations.

To put forth this proposal may sound as if I were advocating the suspension of all research until a master plan—made by master minds—is formulated. Such is not my intention, although I do think that attempts at general systematization are long overdue. What I do mean is that in the present state of the profession those who would undertake research must be prepared to give much more attention to formulating their problems and discovering out of what they arise than do workers in other professions. I also think that the search for feasible and needed investigations can take its start from a consideration of what is vague, obscure, not agreed upon about the nature of the phenomena to which social work is addressed.

If the formulation of social-work research projects proceeds from that point, social workers may avoid several of the errors to which research in their field seems especially liable. They will, for example, avoid the clinical fallacy that consists of generalizing far beyond the population that the sample studied represents. This is an error that psychiatric research workers also make at times: the error of thinking that by understanding the morbid, they will also understand

the healthy or—in social-work terms—that by studying their clients, they will have something valid to say about all persons who have similar problems. This error will be avoided because the research, from the outset, will be oriented toward discovering something about social-agency clients and about work with them (that is, something about the nature of the phenomena with which social work deals) and not something about people in general.

Of course, at times social workers will want knowledge about some general population in order to understand their clients (many young delinquents, for example, may be following the pattern of most well-adjusted boys in their cultural groups), but, if so, their inquiries will again be directed toward a specified group, and they will choose representative samples of it on which to base their conclusions.

Another error that social workers may avoid by starting from clearly formulated questions and hypotheses is that of assuming what they are trying to discover. I have found that social-work students have little understanding of how causal or contingent relationships are established. If they ask, for instance, why some clients break off contact with a clinic, they are inclined to think that the answer is to be secured by discovering the reason in each individual case and then summing these explanations. Obviously, if this can be done—that is, if this information about each case is already at hand—what is needed is not research, but a compilation of statistics. If, however, the research starts with the hypothesis, or hunch, that the explanation of such conduct on the part of the clients may be this or that, the investigator will be led to compare the incidence of this or that in the designated cases and in those of the opposite variety. Such an inquiry may not tell him *why* people break off contact, but it may give him equally useful information as to *which* people do this undesired thing. And in this *which* the *why* may be concealed.

At this point it must be added, parenthetically, that the use of a control group must not be elevated to a scientific *sine qua non*, for there are many problems to which it is not applicable. The point to keep in mind in planning all research, however, is that in addition to formulating a clear-cut question, one must devise a logically sound scheme by

which the question can be answered. One must not wait—as our students are prone to do—until the data are collected before considering to what use they will be put—if only because, in so doing, one is likely to find that one has collected the wrong data.

The planning of research in social work follows, then, the same rules as that in other disciplines. One must start with a clear idea of what it is that one is in doubt about. The reasons for that doubt must be made explicit and the various alternative explanations or hypotheses or simple hunches must be lined up. One must next determine just how the question is to be answered. This depends, of course, on the nature of the question. Sometimes it is possible to answer the question by a simple analysis and enumeration of its constituent parts, as when we want to know, usually for administrative purposes, who are our clients with respect to certain pertinent characteristics. (Which characteristics are pertinent to social work is, however, another and more difficult question.) Sometimes a control group is called for, as when we want to know whether certain measures are effective or whether certain explanations are valid. In such investigations, what constitutes a valid control (what factors, that is, are to be controlled) and what is being tested by it, are extremely important. It is by no means sufficient to be certain that the two series of individuals are similarly distributed in age, sex, and I.Q.; nor does the presence of even a good control group compensate for vagueness and indeterminateness in the measures under investigation. In other studies there is no place for a control group, as when, in evaluative investigations, the search is for the distinguishing characteristics of the persons who have been aided. In such studies, intra-group comparisons take the place of an external control group, and conclusions can be drawn by contrasting the successes and failures.

For other kinds of questions, other devices are called for in the search for answers. The important thing is to see, from the outset of the research, the broad outlines of what it is that is to be answered and how that answer is to be secured. As I said at the start, this is more difficult in social work than in other professions because the theoretical substructure is so poorly developed that each investigator must

formulate the hypotheses and define many of the concepts before he can proceed, as well as because there are so few examples of research method to follow. Then, having planned the investigation and made its questions clear, one must not lose one's sense of direction in the long interval between start and finish. It is here that it is most difficult to provide rules. The situation is something like that in the calculus, where the rules of differentiation are specific, but integration requires imaginative effort. Here, again, social-work research seems to be more difficult than that in better developed fields, perhaps because we attempt to study too complex problems or try to answer too much at once.

However that may be, the research situation in social work—and perhaps social work itself—would be improved if those well versed in the field and with analytic interests would line up the known and the unknown, the agreed-upon and the unsettled, and state the propositions in terms that are clear and determinate. If this were done, social work would be on the way to being a profession in Whitehead's sense of the word.

RESEARCH IN PSYCHIATRIC NURSING *

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ANY discussion of research in psychiatric nursing is based upon several assumptions. First, psychiatric nursing is professional in type. The psychiatric nurse is a member of a team working for the welfare of the patient. She is a co-worker with the psychiatrist, the occupational and recreational therapists, and the social worker. She has her own sphere of activity, which involves more than insuring that the patient's physical wants are satisfied. It is her responsibility to direct his activity, control his environment, and participate in his therapy for most of his waking hours.

Second, any research in psychiatric nursing should aim at improving nursing care. Research is of no value if it does not achieve this end, either directly or indirectly, through better prepared personnel.

Third, research is needed in psychiatric nursing. Most of our nursing is carried on almost empirically. Through experience, we have learned to use positive suggestion with some patients, persuasion with others, while with others we use reassurance. In general, however, we have not subjected the use of such techniques to scientific study. We have emphasized the art of psychiatric nursing and have almost ignored the science. Our patient care would be more effective if we knew more specifically how, when, and why we used certain techniques, and if we did more to discover new techniques that we might utilize.

A fourth assumption upon which this discussion is based is that research in psychiatric nursing may be carried on at several levels. A complicated problem may be set up which, for its solution, requires trained personnel, money, and time. On the other hand, there are many problems that

* Presented at the Third Annual Coordinating Conference of the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, April 1, 1943.

may be solved in the average ward situation. After all, much of good psychiatric nursing is research in its broadest sense. To be specific, if a patient does not eat, the nurse's problem is to determine how she may manipulate her methods of care so that he will eventually eat as a matter of course. She tries to determine why he is not eating, and then, on the basis of her findings, she sets up a plan of action. In this discussion, primary emphasis is given to problems at the latter level.

The several areas in which research may be carried on in psychiatric nursing may be classified under the following headings: patient care, nursing service, and curriculum.

Research in the nursing care of psychiatric patients presents several difficulties which must be recognized and understood at the outset. At the same time, they offer a challenge. The first lies in the nature of psychiatric nursing, which involves, to a considerable extent, personal interaction or nurse-patient relationships. The components of this type of care are much less tangible than those that have to do with purely physical needs. It is easy to determine whether a patient is clean and tidy, and whether he eats his meals. How this is achieved by the nurse, is less tangible. Nevertheless, this aspect of psychiatric nursing is extremely important for the ultimate welfare of the patient. Likewise, in any personal interaction there are many variables. A patient may react to the suggestion of one nurse in one way and to that of another in an entirely different way. At different times, he may react to the same nurse differently.

A second difficulty in research in the nursing care of psychiatric patients lies in the fact that psychiatric treatment and nursing care overlap. A patient has adjustment problems which he may discuss with the nurse. The solution of these problems may well be the responsibility of the psychiatrist rather than of the nurse. Coöperation with the psychiatrist is implicit in any nursing care. In setting up any research problem, the line between therapy and nursing care must be recognized. Although coöperative research by the nurse and the psychiatrist can be, and should be, carried out, pure nursing research must not overstep its bounds.

A third difficulty in psychiatric-nursing research is that

treatment and nursing care are individual for each patient rather than specific for a diagnosis. Although the textbook picture in schizophrenia is well recognized, patients who are diagnosed schizophrenics differ markedly in behavior, and, therefore, require different care. This creates a problem in establishing generalizations and principles that will be applicable in the care of all schizophrenic patients by a number of different nurses in a variety of situations.

In spite of these difficulties, there is a wide range of problems in the nursing care of patients that we can attempt to solve. Experimentation may be carried on in conjunction with the daily care of patients. Do we know as much as we should about the control of patient environment? What is the effect of the behavior of other patients or of the personnel upon that of a specific patient? Through experimentation with the grouping of patients while they are engaged in various ward activities, we might well learn more than we know at present.

What new techniques may we employ in our nurse-patient relationships? Does the approach of non-directive counseling have any place in psychiatric nursing? If so, with what types of patient and how extensively can it be utilized? Are we concentrating on the physical wants of the patient and ignoring others just as essential? If so, what are the unmet wants?

A study of pediatric nursing,¹ recently completed under the direction of the Department of Studies of the National League of Nursing Education, should provide help in solving this problem. In this study, both the physical and the psychological components of pediatric nursing are defined in terms of the behavior of student and graduate nurses and of auxiliary workers. The definitions of the psychological components of care should be particularly suggestive for us, since pediatric and psychiatric nursing have many common elements. By an objective study of such problems, we

¹ See *A Study of Pediatric Nursing*, sponsored by the United States Children's Bureau and the National League of Nursing Education in coöperation with the New York Hospital, New York, N. Y., and directed by the Department of Studies, National League of Nursing Education. New York: National League of Nursing Education, 1947.

should develop new principles of care which will be applicable in a variety of situations.

Several methods may be utilized in research in patient care. One is the traditional method of setting up two groups—one the group on which the experiment is carried out and the other a control group to which the usual type of care is given. Determination is then made of what improvement, if any, has been achieved in the care of the experimental group. In a ward situation this method may readily be employed.

A second method that may be utilized in any ward situation is group analysis of practice. Careful, objective records are made of the total nursing situation—a description of the environment, the behavior of the nurse, and the results achieved. The records are then subjected to review by the nursing group in order to determine, in the light of present knowledge, what changes in the behavior of the nurse might have resulted in better nursing care in that particular situation.

A third method that may be employed in any ward also involves a study of records of nursing care. The records of a group of nursing situations of a similar type, such as management of patients who are overexcited, may be analyzed to determine which factors in nursing care contributed to successful care and which to failure. On the basis of analysis of a sufficient number of such records, generalizations may be made that should be useful in comparable situations. This type of study should be extremely valuable to individuals in the group. It subjects the behavior of each individual to analysis and criticism by the group, and requires each individual to think consciously of why she reacted as she did. In addition, if, as a result of this type of study, information can be built up for the use of all psychiatric nurses, it will be an important forward step.

It must be recognized that any method that makes use of this type of record has certain shortcomings. Data are incomplete. It is impossible to secure the complete picture from memory. The records must be objective—a record of facts, not the nurse's opinion or interpretation of what was said and done. It is difficult to secure an objective record

and it requires considerable practice. On the other hand, psychiatric nurses have had considerable practice in preparing objective records, so that this shortcoming of the method may not present as great a problem for this group as for some others.

In order to secure objective information about a nursing situation, an observer may be utilized to make notes of the behavior of the patient and of the nurse. This technique is frequently not feasible because the presence of a third person may create an atypical and distorted situation. An observer's record is also incomplete. Even if it is secured in shorthand, it is impossible to include everything said and done by both patient and nurse.

In some situations, it may be possible to use a recording machine. This method is objective and accurate and complete, but it is obviously impracticable in many situations. Nevertheless, it is a device with which we should be experimenting.

In addition to investigations in the improvement of patient care, studies should be made in the improvement of nursing service. Unless our practices are far better than those in many general hospitals, a study of our routines and procedures would show that some are unsound scientifically, or even unsafe. Many originated at a time when much less was known about bacteriology than at present, and others were set up by individuals who had only a limited background in physical science. They have not been evaluated in terms of modern knowledge and have been carried out in the same way through the years.

A broader study in nursing service might be one of the use of professional and non-professional personnel. It is common knowledge that the latter group is extensively used in the care of psychiatric patients. There has also been considerable publicity given to the need for more professional nurses. However, if we face facts, we must admit that we can never expect to have professional nurses make up the majority of the personnel engaged in the care of psychiatric patients, except in a limited number of hospitals. The potential supply of young women in the country is not great enough to meet this demand.

Since this is true, studies should be made to determine how the available supply of professional nurses might be used more effectively in psychiatric hospitals. The personnel necessary to give various levels of care should be more carefully determined through time and activity studies. For example, how much and what kinds of personnel are needed in the purely custodial care of various types of patient; what are the needs when various types of shock therapy are used; and what is needed if an active program of nursing is to be carried on?

Activities assigned to professional and non-professional personnel should be carefully scrutinized. A recent study¹ of the use of non-professional workers in obstetric-nursing services has shown that nurses in some hospitals are still routinely cleaning utility rooms and cupboards for unsterile equipment. On the other hand, in some hospitals, practical nurses are catheterizing patients. In other words, there is a lack of clear definition and differentiation of function. Through the type of activity assigned to nurses, some hospitals are wasting money and human resources.

If a similar study were made in psychiatric hospitals, similar findings might be obtained. Questions that might be considered are whether secretaries are being employed as extensively in the nursing office and in the wards as is possible, and whether nurses are carrying on purely routine activities that might be carried on by other groups.

A third area in psychiatric nursing that merits further research is that of the curriculum. Its organization might well be restudied. The *Curriculum Guide for Schools of Nursing* departed from diagnosis as a basis for organization of content of the course in psychiatric nursing and utilized the behavior of the patient. This is probably much sounder, as nursing care is based on behavior rather than upon diagnosis. However, in the *Curriculum Guide*, content to be secured through clinical experience is segregated from that to be acquired through classroom experiences and outside study. For example, "Care of the Underactive Patient" is a separate unit in the section dealing with clinical expe-

¹ See *The Use of Non-professional Personnel in the Nursing Care of Obstetric Patients*, by Rozella Schlotfeldt. Unpublished master's thesis in Nursing Education, University of Chicago, 1947.

rience. Theoretical background for the care of this type of patient is included in a second section in a unit dealing with the care of representative types of patient.

If our objectives focus on patient care, is this segregation sound? Are not classroom content, clinical experience, and outside study all directed to achieving one set of objectives? Should not units be set up so that all the student's experiences will be directed to one end? In other words, all content dealing with the care of the underactive patient should be included in one unit.

This also raises the problem of the organization of content dealing with recreational and occupational therapies and with psychiatric background. Should this content be segregated as it is at present, or should it also be included in the one unit dealing with the underactive patient?

Another type of curriculum problem that might well be studied is that of evaluation. Our methods have frequently been weak. We have stated that a student's work has been good without having clearly defined for ourselves what we meant by that characterization, or without ascertaining whether others interpreted our evaluation as we meant that they should. If we are to evaluate the student's progress objectively and with validity and reliability, we must determine, first, what our objectives in psychiatric nursing are. Then, behavior that indicates acquisition of knowledge, skills, attitudes, and ability to apply principles in relation to each objective must be defined. A third step is to set up devices that will determine to what extent the student's behavior indicates that she has acquired the desired knowledge, skill, attitudes, and ability to apply principles in concrete nursing situations. Lastly, we must be sure that all who will use the measuring devices will know how to use them.

To conclude, we have indicated some of the difficulties in research in psychiatric nursing, as well as types of problem in patient care, nursing service, and curriculum, and methods by which they might be solved. Some require extensive and long-term study for their solution. Others are problems that can be solved in a single hospital unit. The important fact to remember is that we can improve our own nursing care through research. For this, we need a desire to improve

our care, our objectivity, our intellectual curiosity, and our methods of reaching our conclusions. When we have found something new or a new method that is successful, it is our obligation to report it so that others may benefit from our discovery. In this way we will gradually build up the science of psychiatric nursing.

PRESENTATION OF THE LASKER AWARD IN MENTAL HYGIENE *

FOR his outstanding achievements in the education of the physician in the psychological aspects of the practice of medicine, the 1948 Lasker Award in Mental Hygiene was given to Dr. C. Anderson Aldrich, Director of the Child Health Project of Rochester, Minnesota. According to custom, the award was presented at the annual luncheon of The National Committee for Mental Hygiene, which was held this year at the Hotel Pennsylvania, New York City, on November 4. Dr. George Baehr, President of the New York Academy of Medicine, made the presentation, which was accompanied by the following citation:

"It would have been hard to foresee in 1916, when C. Anderson Aldrich began work as a general practitioner in Winnetka, Illinois, that he was to become the leader of a profound shift in pediatric philosophy, the first integrator of pediatrics with preventive psychiatry, and a potent force for mental health, not only in America, but throughout the world.

"In 1927, when pediatric thought was largely preoccupied with physical disease and physical quantities, and when accepted child-training rules had reached a peak of arbitrariness and rigidity, Dr. Aldrich had the wisdom and the courage to write *Cultivating The Child's Appetite*. It persuasively set forth the child's own attitude toward feeding, which up to then had been largely ignored in the science of nutrition, with distressing results. In 1938, Dr. and Mrs. Aldrich wrote *Babies Are Human Beings*. Its title became the rallying cry for the varied professional groups and parents who were concerned with the importance of understanding broadly the nature and needs of children. In these books Dr. Aldrich provided the inspiration, leadership, and authority, from within the field of pediatrics, that were vitally necessary for this point of view to prevail. *Feeding Our Old Fashioned Children*, also written in collaboration with Mary Aldrich, appeared in 1941. These books have been translated into four languages and have reached a vast and influential audience.

"As officer of pediatric societies and of the American Board of Pediatrics, as author of medical papers, and as teacher of physicians in training, Dr. Aldrich has constantly and successfully drawn the attention of the profession to the developmental and humanistic aspects of pediatrics.

* The Lasker Award in Mental Hygiene, established in 1944 by the Albert and Mary Lasker Foundation, is an award of \$1,000 presented annually for an outstanding contribution in some field of mental hygiene.

"In 1944, he was asked by the Mayo Clinic to organize the Rochester Child Health Project. Under his leadership, pediatricians, psychiatrists, psychologists, nursery-school educators, and nutritionists work in coöperation with city health officers, public-health nurses, and the schools, to discover and provide the best preventive care, physically and emotionally, for all the children of the city.

"Dr. Aldrich's soundness in psychological approach to pediatrics is not due to any formal psychiatric training, but to love of people, unprejudiced observation, and a natural immunity to fad and dogma. His success as leader and persuader comes from many qualities, but perhaps the most important are his imperturbable good nature, his disarming selflessness, and a perseverance that never irritates, but never gives up."

The Lasker Award in Mental Hygiene has been presented four times before. The first recipient, in 1944, was Colonel William C. Menninger, Chief Consultant in Neuropsychiatry, Office of the Surgeon General, U. S. Army, for his outstanding contribution to the mental health of the men and women of the armed forces. The next year it was divided between Brigadier John Rawlings Rees, Consultant in Psychiatry to the Directorate of Psychiatry of the British Army, and Major General G. Brock Chisholm, Deputy Minister of National Health, Federal Department of National Health and Welfare, Canada, for their services in the field of rehabilitation. For the next two years it was again divided. In 1946, half went to Dr. W. Horsley Gantt, head of the Pavlovian Laboratory at Johns Hopkins University, for significant experimental investigation into behavior deviation, while the other half was given jointly to Dr. D. R. Sharpe, of the Cleveland Baptist Association, and Mr. Walter Lerch, of the *Cleveland Press*, for an outstanding contribution to the advancement and improvement of public mental hospitals. In 1947, the recipients were Miss Catherine Mackenzie, editor of the column "Parent and Child," in the *New York Times Sunday Magazine*, and Mr. Lawrence K. Frank, Director of the Caroline Zachry Institute of Human Development, New York City, for their contributions in the field of popular adult education, particularly in parent-child relationships.

BOOK REVIEWS

THE SOCIOLOGY OF CHILD DEVELOPMENT. By James H. S. Bossard.
New York: Harper and Brothers, 1948. 790 p.

There are many books on the physical, psychological, and psychiatric aspects of child development, but very few on the child's social orientation. This is a curious fact, considering that the sociologist has taken the study of the family as his province. In developing his interest in the family, the sociologist first concerned himself with social history and social problems and only later turned to the study of the development of personality in the family. At present a major focus of interest is marital adjustment. In all of this the rôle of the child has been ignored. Hence the special significance attaching to this book of Bossard's. It makes an entry into a sorely neglected field and may be a portent of things to come.

By a sociology of child development, Bossard means an analysis of child development in terms of (1) social situations and (2) cultural conditioning. From birth, the child finds himself a member of various groups, like the family, the school, the neighborhood, and the gang, which serve as instrumentalities for the transmission of the social heritage. Bossard accordingly sets out to analyze the development of the child in terms of his group and cultural experiences, beginning with those centered in the family.

After an introductory Part I, Part II deals with the child and his family setting, encompassing family structure, process, interaction between siblings, and family culture. Part III covers such "facets of family life" as family table talk, modes of expression, the rôle of the guest, and of domestic servants. Part IV deals with "class and status differentials"; Part V with "problem families," by which Bossard means problem homes with children rather than homes with problem children. Part VI carries on the child's development through non-family groups, including school, peer groups, and the community. Part VII concludes on a more general theme: "The Changing Status of Childhood."

Here, then, is a trail-blazing book in a new and uncharted field. Under the circumstances, it can be but exploratory and suggestive, rather than comprehensive and definitive. It furnishes an outline of what a sociology of the child may be and makes an important beginning in filling in the outline. There is much original and stimulating material in the book, the product of Bossard's own

researches, some previously published, some appearing in this book for the first time. The use of autobiographical studies of childhood is excellent. The book also has the virtue of being highly readable.

M. F. NIMKOFF.

Bucknell University, Lewisburg, Pennsylvania.

THE CONTEMPORARY AMERICAN FAMILY. By Ernest R. Groves and Gladys H. Groves. New York: J. B. Lippincott Company, 1947. 838 p.

The first college textbook on the family and its problems, entitled *Social Problems of the Family*, by the late Ernest R. Groves, was published in 1927 and used in the author's classes on this subject in a department of sociology. Since these pioneer efforts, there has been a great increase in lay, academic, scientific, medical, psychiatric, and religious concern with problems of courtship, marriage, child care and training, and the family, as the basic unit of society. These and related subjects are now receiving more serious attention in many colleges and universities.

Dr. Groves later became Director of the Marriage and Family Council at the University of North Carolina. In 1934, *The American Family*, by Ernest R. Groves and Gladys H. Groves, was published, of which the publication under review is a rewritten and reset edition. The purpose of the book is "to give the reader an understanding of American family life that will help him to handle his own problems, whether they are associated with pre-marriage, marriage, or parenthood experiences."

Divided into four parts, the first section of 201 pages is concerned with an historical survey of the family, the variations found in different times and places, and the influences that have molded the American family to-day. This section seems extremely dull reading and unnecessarily drawn out. In the second section, only 76 pages are devoted to the psychological aspects of American family experience, in which the emotional, behavior, and personality growth in family life and experience is considered. Although there are accessible rich mines of case material in the files of medical, psychiatric, and case-work agencies and in the professional publications of these groups, such material has not been used. The illustrative cases seem to have come from social observation or from the files of a general counselor.

Under the third major heading of social problems of the American family, the rapid sociological changes that have affected family life in the United States are considered. Courtship, marriage, the arrested, the broken, and the incompatible family, the problems of

divorce and desertion, and the criticisms and attacks that have been made on the family are also analyzed.

The fourth section contains a survey of the specialized programs for the conservation of the American family, including the legal, biologic, medical, mental-hygiene, home-economics, and educational approaches, and the outlook for successful family life is evaluated. In the appendix is a bibliography on family experiences as illustrated in fiction, plays, biography, and autobiography. There are also lists of subjects for reports, and references to books and articles as supplementary reading for each chapter in the book.

In some ways this is doubtless a valuable book, for it will give the inexperienced student a broader perspective on the family and the forces that play upon it than he could quickly obtain in any other way. Unfortunately, it is written in a remarkably colorless, generalized, and involved prose style, which is the bane of all textbooks. This reviewer, a veteran of long and varied reading, finds it practically impossible to plod through any textbook written by academic authors for the enlightenment of the young without falling asleep. The authors and publishers of textbooks seem to be completely unacquainted with all modern experiments in the making of attractive books, with animation, illustration, and appeal to readers. Perhaps the pundits who write textbooks for youth should make a practice of turning their material over to creative writers, experienced in getting over ideas to the public and familiar with all the devices in the use of type, illustration, color, and styles of make-up that are useful in attracting and holding readers. The book could also have been made more helpful to students if it had been enlivened by a far greater use of brief, pertinent case illustrations.

The book is mainly a careful sociological survey, which will give a broad background of general knowledge. It is not a book that will give the student much specific knowledge or help with concrete problems of individuals in relation to physical, mental, or sex hygiene or child care and training.

The book has been read and approved by Edgar Schmiedeler, of the Catholic University; L. Foster Wood, of the Federal Council of Churches of Christ in America; Rabbi Sidney Goldstein; and Dr. Robert L. Dickinson.

CLARA BASSETT.

New York City.

PSYCHOTHERAPY IN CHILD GUIDANCE. By Gordon Hamilton. New York: Columbia University Press, 1947. 340 p.

While this book by Gordon Hamilton, professor of social work at the New York School of Social Work, Columbia University, resulted

from a study of the child-guidance program of the Jewish Board of Guardians (a New York social agency), it is much more than just a report on the work of the agency. First of all, it is a treatise on diagnostic and therapeutic processes in work with children; secondly, it is an argument in favor of social workers' doing psychotherapy—but only after highly specialized training beyond the usual education for social work.

As a contribution to the literature on child-guidance therapy, it is a welcome addition to what is available in that field, for it has certain unique aspects as compared to what has previously been written. So far as the reviewer knows, it is the only book on psychotherapy with children outside of the literature on child analysis that describes an approach based entirely and consistently upon a Freudian orientation. More than any other book on the subject, it emphasizes careful methods of diagnosis, differential diagnosis, and the need for variations in therapeutic techniques to adapt them to the type of problem as diagnosed and to the age of the child.

It is also a presentation of psychotherapy as carried on by social workers, under the supervision of psychoanalytical psychiatrists. Thus it differs significantly in at least these three respects from other writings on child-guidance therapy. This remains true regardless of possible differences of opinion among readers as to whether Freudian principles have been correctly applied, or possible controversy over the Freudian versus some other viewpoint.

The twelve chapters are preceded by a foreword by Nathan W. Ackerman, M.D., a preface by the author, and an introduction by Herschel Alt. Eight of the twelve chapters focus on the child and on diagnosis and therapy for the child. Two chapters are devoted to the child's environment and the necessity of influencing it to support psychotherapy with the child. The first and last chapters center on the social worker's suitability and training for psychotherapy. The fact that two-thirds of the chapters are on work with the child justifies the statement made at the beginning of this review regarding the book's being a treatise on diagnosis and psychotherapy.

The individual chapter headings are as follows: I. *Clinically Oriented Social Case Work*; II. *The Diagnostic Process in Child Guidance*; III. *The Child Who Acts Out His Impulses*; IV. *The Anxious Child*; V. *The Severely Disturbed Child*; VI. *Direct Treatment in the Therapeutic Process*; VII. *The Therapeutically Conditioned Environment*; VIII. *Treatment of Young Children*; IX. *Treatment of the Older Child*; X. *Treatment of Adolescents*; XI. *Treatment of the Family*; XII. *Preparation for Psychotherapy in Social Work*.

Although written from a strictly Freudian viewpoint, a good

deal of the material in these chapters should be acceptable to all child-guidance workers, even those who do not adhere to Freudian theories. There should be no quarrel with the statement, for example, that diagnosis should take into account data from observations of the child and from medical and psychological examinations, and should consider the family relationships and other environmental circumstances. As in many clinics, medical and psychological studies apparently are not routine, but are utilized when deemed necessary for the individual case.

Detailed histories are regarded as an important contribution to diagnosis and there should be no criticism of this, despite the fact that the historical orientation was, as the author remarks, for some time "out of fashion." However, one use of the history, to establish at what stage of emotional development a child's symptoms or behavior deviations began to appear—whether in pre-Edipal or Edipal stages, for instance—may not be characteristic of all child-guidance programs; it stems logically from the Freudian approach represented by this book, however.

So far as the clinical types and the diagnostic categories described in the third, fourth, and fifth chapters are concerned, these again should be fairly well accepted, whether or not the chief viewpoint is Freudian. Most child-guidance workers would differentiate between the child who is reacting aggressively to unfavorable parental relationships, the child who has internalized his conflicts and carries them even into a more favorable environmental setting, and severely disturbed children, including the extremely neurotic, the pre-psychotic, and the actually psychotic.

One of the most valuable aspects of the material on therapy with children is the consideration of adaptation of techniques to the type of problem and to the age of the child. These chapters should be exceedingly helpful to persons who are starting to work with children, whether they are psychiatrists, psychologists, or social workers. The author is careful to mention, in several places, however, that social workers should not undertake therapy with children who are suffering from organic diseases or who tend too much toward the psychotic.

One of the most interesting parts of the chapter on treatment of adolescents is the brief discussion of adolescent unmarried mothers. There is also a brief note on some of the problems in working with parents of adolescents because of adolescent attitudes toward parents.

To any one working in the child-guidance field, the chapter on treatment of the family will be as interesting as those on the child. Many of the comments about parents will strike a familiar chord in terms of our own clinical experience and the development of

our thinking about parents. We have, for example, all had to learn that we do not have the right to compel parents to bring a child for treatment; that we must approach parents with the attitude of enlisting them in the project of removing obstacles to the child's healthy development, instead of regarding them as the chief obstacles to it; that there are strengths in parents which can be drawn upon, even if the only sign of such strength at first visible lies in the decision to face the fact that a child has a problem and to seek help for the child.

It would be tempting to continue indefinitely with comments about the material in this book; there is so much more that could be said. It shows such conscientious and careful workmanship that it must certainly command professional respect. Only one slip was noted by the present reviewer. This is in one of the illustrations of the need to consider a child's age in making a diagnosis (p. 23): "For instance, with schizophrenics the changes typically occur at the onset of puberty; if extreme loss of interest, neglect of possessions, and so forth, occur in the young child, one must think of the possibility of organic disease." It is evident from a further discussion of the schizophrenic (pp. 109-110), that the author is familiar with the fact that this condition sometimes does appear before puberty and even in pre-school-age children. It is unfortunate that the sentence quoted above could be misinterpreted as implying that a diagnosis of schizophrenia should not be considered before the age of puberty, whereas it was probably intended to mean that since schizophrenia is less common in childhood, other possibilities should be ruled out first. In view of the high standards of accuracy maintained in the presentation of the material in this book, the statement on page 23 should be reworded to avoid any chance of ambiguity.

Gordon Hamilton has written a book that is not easy reading, but that requires effort and concentration. This is due to its being such a thorough exposition of the viewpoints and methods that it represents. Since it deals with the question of social workers as therapists, it is as well that it is difficult to read. Perhaps this will help to deter social workers who read it from believing that it is a simple matter to do therapeutic work with children. A great deal of special training beyond that ordinarily required for social work is necessary for the worker who is to be entrusted with psychotherapy. If this book should accomplish no more than acceptance of that fact, it would have been well worth the time and energy that must have gone into it. Psychologists have lately achieved more adequate standards for the education and training of clinical psychologists, and social workers may be at the point where they must formulate standards for those in their profession who wish

to engage in therapy. Perhaps Gordon Hamilton's book, particularly its last chapter, will serve as an impetus to social work to attempt this formulation.

PHYLLIS BLANCHARD.

Philadelphia Child Guidance Clinic.

CHILD OFFENDERS—A STUDY IN DIAGNOSIS AND TREATMENT. By Harriet L. Goldberg. New York: Grune and Stratton, 1948. 215 p.

Dr. Goldberg is eminently qualified to discuss the phenomenon of juvenile delinquency in a scientific way. She was case supervisor in the New York City Department of Welfare; taught courses in public welfare, case-work, delinquency, and community organization at Hunter College, New York; and is now associated with the Domestic Relations Court in Toledo, Ohio. The present book is based upon her experiences as assistant corporation counsel, assigned to the Children's Court of New York City. More particularly, she was working in the "School Part" of this court.

The establishment of this special division in the Children's Court of New York City was authorized in April, 1944, in order to handle cases of truancy, unlawful detention of children from school by parents or guardians, and misconduct within school, separately from other cases of child delinquency. The immediate reason for the setting up of this special division was the feeling that in view of the large volume of the juvenile court's total case load, cases of truancy—which is often "considered a lesser offense than theft, assault, etc."—would not receive the attention they deserve. The purpose of this new division was "to seek fundamental causes of persistent truancy and to help these offenders sufficiently to prevent their becoming serious delinquents."

The author describes in some detail the pre-judicial, the judicial, and the follow-up phases of the School Part's functions, and the composition of the staff, which consists of attendance officers, psychiatric social workers from the Bureau of Child Guidance of the New York City Board of Education, police officers from the Juvenile Aid Bureau, and other clerical personnel. The character of the staff indicates that there is the closest coöperation between court, school, and other health and welfare agencies. During the first two years of its existence, this special division, through informal hearings, handled the cases of 2,000 children, most of whom were referred by the Bureau of Attendance of the New York City Board of Education.

Almost three-fourths of the book consists of case histories, of from one to two pages each, selected from the files of the School

Part with brief explanatory notations containing the author's prognosis. These cases are systematically organized in chapters headed as follows: *Mentally Retarded Children, Emotionally Unstable Children and Those with Neurotic Patterns, Neurotics and Psychoneurotics, Psychopathic Personalities and the Mentally Ill, and The Physically Ill and the Socially Handicapped.*

In the last chapter, "a challenge to community organization," is presented. Analyzing various panaceas that are offered in the current public discussion of the juvenile-delinquency problem, the author rightfully condemns the present vogue of blaming everything on the parents. "When the circumstances are analyzed," she states, "it is usually found that these people are themselves more sinned against than sinning and require specialized care."

"The lack of a stable home life" is cited by Dr. Goldberg as "the most pervasive element for producing misconduct." Physical defects and scholastic retardation are others.

Although in the handling of cases of juvenile delinquents much attention is paid to the diagnosis, the author feels that a great deal still remains to be done in refining the diagnostic process. "One reason why habitual truancy is often the beginning of a delinquency career is that expert study is not given truants at the inception of their chronic absences."

Speaking more specifically of medical diagnoses, Dr. Goldberg states that the findings of physical examinations are much more readily received by judges than psychometric and psychiatric reports. She blames the psychologist's and the psychiatrist's tendency to use abstruse and obscure terminology.

Discussing the treatment as such, the author calls for more social-service counseling in the children's courts and the schools. She emphasizes the need for additional psychiatric facilities and criticizes the "well known system [in New York] of subsidies for private child-caring institutions as a substitute for public care," which brings about overlapping of services for certain groups and lack of facilities for other groups. For instance, "in New York and elsewhere, too, it is practically impossible to find a placement for a Protestant child offender, especially if he is a Negro" (p. 200).

A discussion of the "children's courts," covering exactly four pages, is full of interesting and partly valuable suggestions, but is too sketchy, considering the importance of the subject matter. Your reviewer cannot agree with the author's contention that the juvenile court's jurisdiction over delinquent, dependent, and neglected children fails to cover all children "who need the court's aid." The definition in the state laws, many of which are modeled after the "Standard Juvenile Court Act" (of the National Probation Asso-

ciation) usually is very wide and all-inclusive. In other respects your reviewer is in full accord with the author, especially regarding the need for an alert in-service training program for probation officers, the value of qualitative research in the courts and probation departments, and the necessity of a vigorous public-relations program by the juvenile court.

It is somewhat surprising to find that, toward the very end of the book, the author—though appraising the School Part of the New York City's Children's Court as a valuable experiment—"is convinced that its program should be merged with that of other divisions, as truancy and school misconduct are not fundamentally separable from other symptoms of maladjustment, such as stealing, sex offenses, etc." All that she gives as a reason for this statement is that "in the interests of children structural and functional integration is imperative" (p. 213).

In parts the book is repetitious; the Rorschach test is referred to as a psychological device, almost to the exclusion of any other suitable test; the last chapter, *A Challenge to Community Organization*, would gain if there were more subheadings.

The book is a very welcome contribution to the field, primarily because of its wealth of case material, which is presented in a concise and precise way, but also because of the practical suggestions for the improvement of services, as contained in the last chapter. In this connection, the reviewer endorses the following statement by Edwin J. Lukas, Executive Director of the Society for the Prevention of Crime, New York City, in his Foreword to the book: "In the last analysis the value of this book—like that of every other work in this field—depends upon the use to which the reader puts the material herein embodied. Here it has been stored; it is for you to extract what is useful—and use it!"

JOHN OTTO REINEMANN.

Municipal Court of Philadelphia.

YOUTH IN TROUBLE: STUDIES IN DELINQUENCY AND DESPAIR. By Austin L. Porterfield. Fort Worth: The Leo Potishman Foundation, 1946. 135 p.

The past few years have brought about an increased interest in the problems of delinquency and, with it, a willingness to re-assay the mainsprings of social organization. This has been the case during and after all major social crises, of which the last war years were merely the most recent. Viewed in this light, Professor Porterfield's book, *Youth in Trouble*, might be considered as just another book on juvenile delinquency.

This slender volume, however, does attempt to analyze the problems

of delinquency and their individual, familial, and community setting and causes, as well as to present enough original case-study material to make the problem one of real human beings rather than merely an academic problem used to illustrate a broad, impersonal social theory.

In attempting to evaluate the causes of delinquency so that intelligent planning may be possible, Professor Porterfield reemphasizes the fruitlessness of the ever-present tendency to pass the blame from the individual delinquent to his parents and family, and on, in turn, to the neighborhood, to the community, and to the social order in general. His main point is that, although the care and training of the new generation is the responsibility of all of these individuals and social agencies, each of them also stands in need of assistance. An over-all program can be realized only when the entire community can be organized for the benefit of youth and their parents and when these youth organizations cease to be adult- or upper-class-controlled and include all the children of all the parents.

The volume is built around six main chapters or units: I. *Delinquents and Complainants in Court and Community*; II. *Delinquency in Court and College, or Delinquents With and Without Real Trouble*; III. *Despair: An Outcome of the Struggle for Status and Belongingness After Bad Placement*; IV. *Aggression: An Outcome of Social Rejection and Imprisonment*; V. *Isolation and Dissociation: Psychogenic Factors Are Interactive With the Factors of Community and Culture*; and VI. *Why Not Organize the Community for the Benefit of Youth — and Parents?*

The last chapter gives a variety of specific suggestions for organizing a community for child-welfare and recreational purposes. A brief review of community committee experiences is given. A bibliography of about 120 titles related to the field of juvenile delinquency is appended.

Youth in Trouble is not an original contribution to the field of delinquency, and the serious professional student will find in it little that is new. It is, however, well and interestingly written and can be recommended, particularly for the community leader who is long on enthusiasm, but short in the understanding of the technical background of the dynamics of human adjustment and the interrelationships that exist between the individual and his larger environment.

ARTHUR L. RAUTMAN.

Carleton College, Northfield, Minnesota.

SCHOOLS FOR A NEW WORLD. (Twenty-Fifth Yearbook of American Association of School Administrators.) Washington, D. C.: National Education Association of the United States, 1947. 448 p.

The American public-school system is a mammoth enterprise. It undertakes to prepare the children of the United States for the per-

sonal and community responsibilities that they must face as children and adults. This school system is administered by a varied group of administrators, ranging from the rural county superintendent to the superintendent of the huge city system. These school administrators have an official organization called the American Association of School Administrators. Each year this large and influential body publishes a yearbook prepared by a representative committee of the association. The yearbook presumably deals with those issues which are of prime, contemporary interest and concern to educators. Thus any one wishing to acquaint himself with the current trend of thought among school administrators will examine these yearbooks with special emphasis.

The book before us for review is the yearbook of the A.A.S.A. for the year 1947. It deals with the issues before the public schools that in the judgment of leading school men are the most crucial. What are these problems and how do school administrators view them?

The committee of distinguished educators who prepared this report evidently were deeply impressed by the event that shocked the physical, mental, and spiritual world on August 6, 1945. As is the case with all thoughtful and informed people, they were conscious that something new had happened and that, strive as we might to imagine and believe that all would be the same in the future, in reality a new world with new and urgent demands was rapidly developing.

But these educators do not linger long over the frightening aspect of the future with the dreadful bomb. They have a much more important job to do—namely, to tell us what kinds of school this new world must have. Fourteen chapters are used for the account.

Chapter I briefly describes the world crisis that constitutes the new world, and Chapter II follows quickly to show that this political, economic, and moral crisis is indeed an opportunity if—and this is a big *if*—America can “build a school system that is able to explain the issues to the masses of the people.” Then there is a very practical chapter called, *The Power of Education*, in which convincing evidence is presented to prove “that the level of education and technical training is the key factor in determining the general level of income of the nation.” The point is made that just as education is the chief factor on the economic level, so it could be the key factor in all human problems.

Chapter IV, *The Purpose and Function of the Schools*, is in my judgment the best in the book. My enthusiasm for this chapter may stem from a deep conviction that good education must be conceived and executed in terms of sound mental hygiene. Be that as it may, here one finds as clear, concise, and informed a statement of the purposes and functions of education as can be found anywhere.

Chapter V gives a bird's-eye view of the “children and youth to-day

and to-morrow"—how many there will be, what they will be like, something of their needs, and a suggestion of the kind of curriculum that will be required to meet their needs.

Chapters VI to XIII are an analysis of the processes by which the principal problems of the new world can be and are being solved by the schools. The titles will give some hint of their content: *Learning to Live Together; Learning to Work; Some Psychological Considerations; Principles of Social Organization and Action; Coöperative Action—in a Small School; Coöperative Action—in City School Systems; Coöperative Action—in Metropolitan Areas; and Coöperative Action at the State Level.*

The central place given to living and working together as the most important problem of the new world is worthy of note. According to this view, *coöperation* is the core need of modern man. A final chapter presents a philosophy and a method for appraising the schools. The opening paragraph merits quoting:

"In the last analysis the worth of any school must be determined by finding out what changes it brings about in the way children and adults live in a community. It makes no difference how convincing the arguments used to develop a modified course of study are, or how many 'experts' judge it to be a fine one; if the children do not behave more intelligently as a result of going to school, the curriculum is inferior."

This book is no dry, technical, uninteresting report by professional educators for professional educators. It is interestingly written, well-organized, and attractively printed. Any intelligent citizen with a reasonable interest in education will find the book good reading. Every professional person in any way concerned with education will read the volume with keen interest and much profit.

Perhaps the review should close on this complimentary note. It would be pleasant to leave this fine picture in the mind of the reader. How comforting it is to know that, officially at least, the educators of our country have such a clear and accurate vision of the education needed for the new world. But a note of sadness and tragedy cannot be omitted.

The gap between this excellent statement and what our schools really are in the classrooms throughout the country is appalling. There are encouraging exceptions, but in the main our schools, in attitude and procedure, seem to be little changed from the meaningless stereotype of subject-matter drudgery autoeratically administered that they were thirty years ago.

Any one who has had any administrative responsibility knows how very difficult it is to break the crust of custom and keep practical procedures moving forward with the needs of changed times and circumstances. But one wonders if the superintendents who write and read

this fine volume are aware of the real classroom processes and their results in the personalities and characters of children. Perhaps if the public were more enlightened, demanded somewhat more of their schools, and were willing to give school authorities more adequate funds, then the yawning gap between theory and practice would be more rapidly filled.

Can one hope that the men and women responsible for our schools will read and digest this excellent book, or must one fear that, busy with politics and routine, they will leave it neatly placed among other good books that adorn the professional office or study? To say the least, *Schools for a New World* is proof that some of them know what needs to be done.

E. V. PULLIAS.

George Pepperdine College, Los Angeles, California.

A STUDY OF PEDIATRIC NURSING. New York: The National League of Nursing Education, 1947. 112 p.

This brochure gives a detailed description of the conditions and techniques of a study of pediatric nursing. It is well organized and clear in style, and it includes a number of interesting tables and exhibits.

Sponsored by the United States Children's Bureau and the National League of Nursing Education, with the coöperation of the New York Hospital, the study is noteworthy because it reflects serious consideration of the psychological as well as the physical aspects of the nursing care of children. Leaders in the nursing field have attempted, in their own way, to identify the "psychological components" in their practice.

The technique devised for the study of "psychological components" was patterned after that familiar in the study of "physical components." It relied upon what could be observed in specific nurse-child situations on the pediatric ward where the study was made. There was concentration upon the "performance," the "activity" of the nurses observed. An interesting exhibit illustrates precisely what was identified as "psychological components" and gives the evaluation, in each instance, as made by the field worker, a nurse who was highly qualified in pediatric nursing. Among other things, the study revealed that "in psychological skills the level of performance dropped well below the level of performance of physical skills in both graduate and student groups."

The technique evolved is offered as suitable for use in the study of other nursing services. It would appear to have certain definite limitations for the study of nurse-child relationships. Yet, as applied in this instance, it was clearly rewarding. The danger inherent

in it would seem to be that of possibly encouraging a tendency to think in terms of reducing the nurse's part in the human nurse-child relationship to a kit of so-called "psychological skills" which could be taught as such. Trends in the integration of psychiatric and psychological concepts in other professions, such as social case-work and teaching, have not followed this course. Efforts to teach parents "skills," for use in specific situations, have proven of but limited value. The report, wisely, makes allowance for future adaptations in the technique.

The general psychological principles embodied in the report are those commonly accepted. The list of so-called "basic psychological components" is of particular note. It was used as a guide by the field worker and is reported to have been reviewed by a psychiatrist and a nursery-school specialist. It includes, appropriately, concepts that may be recognized as pertinent to constructive relationships of adults with children, generally. Recommendations are made for improving the psychological aspects of nursing care; "time requirements" are emphasized, but, helpfully, mention is also made of the importance of knowledge of "principles of child guidance and child development" and of effective supervision of students.

The part the nurse plays in, temporarily, taking over from the mother many of her functions with the child, as well as in providing manifold medical nursing-care services, is strikingly conveyed in the revealing tables which list the physical activities observed and evaluated.

The reader of this report can be left with no misconceptions as to the challenge to the nurse to consider the emotional as well as the physical needs of the child, or as to the difficulties that confront her. The nurses involved in the study are to be commended for having outlined some of the problems as they see them.

In addition to nurses, the report will be of interest to pediatricians, to psychiatrists, and to social workers, both medical and psychiatric. For all those of other professions who have a part in encouraging the mental-hygiene awareness of nurses, it should certainly be required reading.

KATHARINE M. WICKMAN.

New York City.

PROBLEMS OF EARLY INFANCY. New York: Josiah Macy, Jr. Foundation, 1947. 70 p.

The proceedings of the first conference of the Josiah Macy Jr. Foundation are made available in this pamphlet. A wide range of material is presented, none of it thoroughly, but the value of the publication, as was the intent of its sponsors, lies in the fact that it gives the viewpoints of people from many disciplines.

Professional people are interested in the early relationships of parents and children because of their recognition of the immense importance of these relationships. Hence the material presented is of broad interest. One is glad, too, that this group discussed repeatedly the question of how to obtain useful research material in this field, recognizing as they did so the limitations of purely quantitative data, the values of clinical material, and the problems of making such data usable.

Milton J. E. Senn describes a project at New York Hospital in which prospective parents were interviewed by pediatricians. The project demonstrated that the rôle of physician guide is best begun before the baby's birth. The emphasis upon helping prospective parents meet reality problems and the recognition that mothers need relief from some usual responsibilities if they are to give optimum care to their newborn infants were gratifying.

James Clark Moloney presents the rationale of the Cornelian Corner, emphasizing the group's conviction, based on anthropological studies, that a psychologically healthy race of Americans could be produced by permissive, indulgent, supportive, and consistently loving care of the pre-conscious child. He expresses the philosophy that if we apply ourselves toward correcting the first beginning, the end will take care of itself. The discussion points up the need for more research to substantiate these beliefs. We are warned against seeking a single cause for the psychiatric difficulties of our society.

Margaret Mead's paper gives additional warnings. The study of different cultures points up the danger in overemphasizing any single item in child rearing, even so important a one as breast feeding. A culture must be considered in its total configuration. Our rapidly changing society should be oriented toward preparing the child for a world that is unknown and that cannot be prefigured.

Rooming in, the system of keeping newborn infants in the hospital room with the mother, is another subject discussed. Edith B. Jackson, Richard W. Olmsted, and Kate Hyder, in their several papers, tell how the project is set up in the Grace-New Haven Hospital and the advantages that have accrued for the parents as well as for professional personnel. J. C. Montgomery presents material from the Henry Ford Hospital in Detroit. Margaret E. Fries discusses the advantages of rooming in for the mother, the baby, the physician, and other members of the family.

Sibylle K. Escalona gives a critical appraisal of psychological factors in rooming in. Having shared a hospital room with each of my three babies, I found myself in accord with the advantages discussed by Dr. Fries, but glad that Dr. Escalona sounded certain notes of caution. She points out that a mother is confronted by the infant's crying without the help of the relatives who did the

hundred and one little things that comfort a baby when babies were born at home. A study of a neonate rooming with the mother showed the various causes of crying and the number of things that needed to be done. The question arises whether mothers will become tense and the infant be affected adversely. Again, an infant may suffer from overstimulation by an immature mother. Dr. Escalona feels that only well-adjusted mothers profit by the rooming in arrangement. Questions might well have been raised as to how mother and baby profit by protection from each other for the first few days of the infant's life, when the infant is shortly to be cared for by his poorly adjusted mother. The fact that the poorly adjusted mother may not profit by rooming in seems poor justification for separating all mothers and their newborn babies.

This very helpful pamphlet ends with a paper by Howard C. Walser calling for more scientific material regarding the values of breast feeding, and a paper by Emmy Sylvester giving case material that points to the pathogenic influences of maternal attitudes in the neonatal period.

FRANCES P. SIMSARIAN.

Washington, D. C.

PSYCHIATRY FOR THE PEDIATRICIAN. By Hale F. Shirley, M.D. New York: The Commonwealth Fund, 1948. 422 p.

In the preface of this book, Dr. Shirley states that it is written primarily for the medical student, the pediatrician, and the general practitioner who lack basic training in child psychiatry. It is presented as a foundation on which the pediatrician can add more detailed and more complex psychiatric knowledge. Three objectives are cited—brevity, simplicity, and concentration on the situations that most frequently confront the pediatrician in practice. To say that Dr. Shirley has accomplished his aims would be an understatement. The effortless manner in which the material is presented allows the reader to digest and to absorb with equal ease. One is not forced to ponder about vague theories, nor is one led to believe that present-day psychiatric attainments are capable of solving all present-day problems.

The information gained from a study of 1,000 cases seen in the Stanford pediatric-psychiatric unit is no small contribution toward the evaluation of psychiatric problems. The fact that approximately 85 per cent of these cases were referred by practicing physicians adds to the practical aspect of the study. General conclusions as well as individual examples are used freely throughout the book in order to "bring home" various points. For those who wish to pursue a specific subject, there is an excellent bibliography at the end of each

of the ten chapters, including reading material for children. A short glossary, with simple and lucid definitions, is given at the end of the book.

It is not the intent of this book to serve as a diagnostic and therapeutic index. The situational problems that one encounters in pediatric practice do not lend themselves to sharp and simple categories. It would take several volumes to attempt to cover thoroughly all the subjects to which allusion is made.

The chapter on development and habit training is well done. It is a good résumé of the development of the infant and child in its various aspects. It is knowledge of the range of the normal that is so important to the pediatricist. The vast majority of questions confronting the pediatrician are those involving normal behavior or minor deviations from the so-called mean. The physician's capacity to inform a mother that a certain act or absence thereof is normal at that stage of growth may very well prevent the development of a chain of events that would eventually lead to a major disturbance.

Sexual factors and problems is the subject matter of another chapter. The manner in which the general topic is treated is such that parents, who need aid in coping with the everyday occurrences of childhood and adolescence, could read it with benefit. No formal medical or psychiatric education is needed to understand the points discussed.

The other chapter headings are *Basic Concepts in Child Guidance*, *Physical Factors and Problems*, *Intellectual Factors and Problems*, *Emotional Factors and Problems*, *Environmental Factors and Problems*, *Investigation of Behavior Problems*, *Treatment of Behavior Problems*, and *Mental Health in a Changing World*.

This well-integrated presentation of psychiatric-pediatric material will be of aid to the medical student, the pediatric interne, the general practitioner, and the pediatrician who has not been trained in psychiatry, not only in meeting day-to-day problems, but in stimulating interest in further study of this omnipresent aspect of pediatrics.

MILTON SINGER.

*Babies Hospital and Vanderbilt Clinic,
Columbia-Presbyterian Medical Center,
New York City.*

TEACHING PSYCHOTHERAPEUTIC MEDICINE. Edited by Helen L. Witmer. New York: The Commonwealth Fund, 1947. 464 p.

This is the report of a pioneer project in teaching internists and general practitioners the basic principles of present-day psycho-

therapy. The course was intensive, being confined to a two-week's period, and was carefully organized. It proved popular with the physician students and the reports of its success have resulted in national recognition.

It is not surprising that the experiment was successful. In the first place, a relatively large group of very able and experienced psychiatrists, neurologists, and internists participated in the teaching. For this reason it was possible to give much individual supervision to the students when they interviewed their patients, and also to devote a great deal of time to individual discussion and to small discussion groups. The authors point out that this intimate relationship with the students was the most important factor in the success of the course. In the second place, most of the instructors were men who had made contributions either in the field of psychotherapy or in psychosomatic medicine.

The subjects covered constituted a reasonably comprehensive introduction to psychotherapeutic medicine. The course began with a brief outline of the essentials of a good psychiatric history, followed by informal lectures on general orientation, patient-physician relationships, personality development, common clinical problems, methods of psychotherapy, psychoneuroses, anxiety states, and common psychopathology. There were also special sections on the care of veterans and the physiology of emotions and disease.

Each day the students worked with patients under supervision. Then the clinical problems encountered were reviewed and discussed. Many of the case histories have been included in the book, as well as examples of the actual questions and answers of students and instructors.

This monograph shows what can be done in effective teaching of psychotherapeutic medicine when a large group of specially skilled psychiatrists and internists join forces in a coöperative venture. Ideally, each medical school should have such a group of men as teachers. At the present time most medical schools lack even the beginnings of a staff that could conduct such a teaching program.

This situation can be remedied only by providing funds for fellowship training, and by materially increasing the budgets of the departments of psychiatry and preventive medicine in order to hold the men in teaching when they have been trained.

EDWIN F. GILDEA.

*Washington University School of Medicine,
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NOTES AND COMMENTS

THIRTY-NINTH ANNUAL MEETING OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

The 1948 annual meeting of The National Committee for Mental Hygiene, its thirty-ninth, was held at the Hotel Pennsylvania, New York City, November 3-4. In spite of the fatiguing election night immediately preceding, some seven hundred members and friends of the Committee attended the various sessions of the two-day program.

The opening session, under the chairmanship of Mr. Lawrence K. Frank, Director of the Caroline Zachry Institute of Human Development, New York City, was devoted to "World Mental Health." Dr. Margaret Mead, Associate Curator of Ethnology, The American Museum of Natural History, spoke on "The International Preparatory Commission of the London Conference on Mental Hygiene";¹ Dr. Nina Ridenour, Executive Officer of the International Committee for Mental Hygiene, on "The World Federation for Mental Hygiene"; and Dr. Alexander H. Leighton, of the Department of Sociology and Anthropology, Cornell University, on "The Dynamic Forces in International Relations."²

This session was followed by a luncheon and business meeting for the voting members of the National Committee. Dr. Frank Fremont-Smith, Medical Director of the Josiah Macy, Jr. Foundation and a vice president of The National Committee for Mental Hygiene, presided at the luncheon, substituting for the president, Dr. Arthur H. Ruggles, who was unable to be present because of illness. Mr. Benjamin P. DeWitt, one of the directors of the National Committee, extended a welcome to new members; and Mr. E. K. Wickman, chairman of the nominating committee, presented his report. Elections to the board of directors and to the council followed.

"The National Program for Mental Health" was the subject of the afternoon session. Miss Isabel Leighton, playwright, war correspondent, and author, presided. Five papers were presented: *General Principles of the Federal Program*, by Dr. Leonard A. Scheele, Surgeon General, United States Public Health Service;³ *How the National Mental Health Act Works*, by James V. Lowry, Chief of the Community Services Section, Mental Hygiene Division,

¹ See pages 9-16 of this issue of MENTAL HYGIENE.

² See pages 17-24 of this issue of MENTAL HYGIENE.

³ See pages 25-29 of this issue of MENTAL HYGIENE.

United States Public Health Service;¹ *Some Thoughts Arising from a Preliminary Survey of State Programs*, by Dr. Abraham Z. Barhash and Miss Mary C. Bentley, Director and Assistant Director of the Division on Community Clinics, The National Committee for Mental Hygiene;² *Retention of Responsibility in the Local Community*, by Mr. Samuel Whitman, Executive Director of the Cleveland Mental Hygiene Association;³ and *The Role of the National Voluntary Organization*, by Miss Mary E. Switzer, Assistant to the Administrator, Federal Security Agency.

The second day opened with a session on "Mental Health Bridges (Between the Past and the Future, the Hospital and the Community, the Sick and the Well)." ⁴ Dr. David Corcoran, Senior Director of the Central Islip (New York) State Hospital, served as chairman. Mrs. Marjorie H. Frank, a member of the board of the Mental Hygiene Society of Union County, New Jersey, presented a paper on "The Volunteer"; Dr. Newton Bigelow, Director of the Marcy (New York) State Hospital, spoke on "Opening the Doors of the Hospital to the Public"; and Miss Marian McBee, Executive Secretary of the New York Committee on Mental Hygiene, discussed "The Responsibility of the Citizen."

At the annual luncheon of The National Committee for Mental Hygiene, which followed, Dr. George S. Stevenson presented his report as medical director of the Committee;⁵ and Mr. A. L. van Ameringen, the treasurer's report. The luncheon address was given by Mr. Quincy Howe, of the Columbia Broadcasting System, who spoke on "Perspective on National Health Planning."⁶

The luncheon was also the occasion of the presentation of the 1948 Lasker Award in Mental Hygiene, which was given to Dr. C. Anderson Aldrich, Director of the Rochester (Minnesota) Child Health Project, for his outstanding work in the field of educating the physician in the psychological aspects of the practice of medicine. Dr. George Baehr, President of the New York Academy of Medicine, made the presentation.⁷

The concluding session of the meeting, with Dr. Alexander Reid Martin in the chair, was on "Positive Mental Health." Three papers were presented: *The Age Period of Cultural Fixation*, by Dr. Weston

¹ See pages 30-39 of this issue of MENTAL HYGIENE.

² See pages 40-50 of this issue of MENTAL HYGIENE.

³ See pages 51-60 of this issue of MENTAL HYGIENE.

⁴ The papers presented at this meeting will appear in a future issue of MENTAL HYGIENE.

⁵ See pages 1-8 of this issue of MENTAL HYGIENE.

⁶ See pages 61-70 of this issue of MENTAL HYGIENE.

⁷ See pages 123-124 of this issue of MENTAL HYGIENE.

LaBarre, Associate Professor of Anthropology, Duke University; *Teamwork for the Young Child*, by Miss Elizabeth G. Fox, Executive Director of the Visiting Nurse Association of New Haven, Connecticut; and *Teamwork for Maturity* by Alice V. Keliher, Professor of Education, New York University.¹

The 1949 annual meeting of The National Committee for Mental Hygiene will be held on November 17-18, again at the Hotel Pennsylvania, New York City.

THE THIRD INTERNATIONAL CONGRESS ON MENTAL HEALTH

The Third International Congress on Mental Health, held in London, August 11 to 21, with an attendance of over 2,000 registered members from 55 countries, met in three separate, but related conferences:

August 11-14—The International Conference on Child Psychology.

August 11-14—The International Conference on Medical Psychotherapy.

August 16-21—The International Conference on Mental Hygiene.

The first two conferences were organized according to the usual plan of professional associations, with individual papers read and discussed at each day's program. The Conference on Mental Hygiene was organized and conducted on another plan.

At the outset, it was decided to organize the conference on new lines. Instead of having an overcrowded program of many individual papers, as is usual at professional meetings, it was planned that before the conference, groups would be asked to meet to study, discuss, and write up their findings on various topics and subtopics on the program and also to formulate their conceptions and theoretical approaches to mental health. Thus, it was hoped that the conference would receive, not the findings or theories of single individuals, but the product of group thinking and critical discussion.

It was also decided to ask that these discussion groups (called "preparatory commissions") be made up, not only of psychiatrists, psychologists, and social workers, but of representatives of the relevant professions and disciplines—of medicine generally, nursing, sociology, anthropology, education, ministry, political science, law, economics, and so on.

This broader, multi-discipline approach to the problem of mental health reflects the growing realization that mental health is a social-cultural problem for which we need the resources of all relevant

¹ These papers will appear in a future issue of MENTAL HYGIENE.

knowledge, skills, and experience, and the understanding that comes from these various professions. It also expresses the conviction that for mental health we need to go beyond the clinical diagnosis and treatment of individuals to the study and reorientation of our whole social life and cultural traditions. This was emphasized in the over-all theme of the conference, which was "Mental Health and World Citizenship."

For nearly a year preceding the conference, three hundred preparatory commissions, with some five thousand individual members in twenty-seven countries, participated actively in the discussions groups. The reports of these preparatory commissions were then sent to London, where small editorial groups summarized and digested them, noting conflicts and agreements in fundamental recommendations. These original reports and summaries were then studied and discussed by an international preparatory commission, which met and worked together for two weeks at Roffey Park in Sussex. This commission was composed of some twenty-odd men and women from ten countries, drawn from the professions of anthropology, philosophy, theology, political science, psychology, psychiatry, and sociology.

The International Preparatory Commission undertook first to present to the conference at each plenary session a summary of the preparatory commissions' reports on the topics for each day's session, together with a considered statement of the commission's own views on these questions. The presentation was made by a member of the commission chosen for that purpose. Second, the commission formulated a "statement" on the major theme of the conference, "Mental Health and World Citizenship," in order to focus present-day knowledge and understanding and also to indicate briefly what the newer approach to mental health means in terms relevant to the urgent problems in each country and internationally. Specific recommendations were included in the statement.

This statement by the International Preparatory Commission was examined and discussed during the congress by twenty study groups, composed of those who had participated in preparatory commissions during the previous year and who, therefore, brought the thinking of their group to the discussion of the statement. The reports of these group discussions were then presented to the conference on the last day, as supplementing, amending, criticizing, and, in some cases, opposing the statement made by the International Preparatory Commission.

Copies of this statement are being distributed to all members of preparatory commissions in the United States, to members of dif-

ferent professions and disciplines, and additional copies may be obtained from the International Committee for Mental Hygiene.

After much careful preliminary work on the articles and structure of such an organization, delegate meetings were called and were held in the conference room of the Ministry of Health, Whitehall, London, on Wednesday, Thursday, and Saturday, August 18, 19, and 21, 1948. They were attended by representatives of nearly all the 55 nations at the congress, and, after very full discussion, the World Federation for Mental Health came into being.

This is a body which it is hoped will be increasingly inter-professional. Its membership will be composed of professional societies in the fields that are related to or concerned with mental health, as well as of the specific mental-hygiene societies in each participating country. However many member societies or associations there may be in any one country, there will be only one voting delegate for each country, whatever its size, and this delegate will be chosen by means of some plan of federation within the country itself, so that the voting delegate will be truly representative of all the different member organizations in that country. Member associations will be able to send representatives as observers to the annual meeting of the mental-health assembly wherever that is held.

The federation is incorporated in Switzerland and the details of its constitution and articles, as now corrected, will be circulated in the near future. The president for the first year is Dr. J. R. Rees of England; the vice president, who will become president at the next annual assembly, is Dr. André Répond, of Switzerland. The honorary treasurer is Dr. Frank Fremont-Smith, of New York. These three are *ex officio* members of the board. The honorary secretary, until such times as funds are available and it is possible to open an office with a secretariat in Geneva, is Dr. Kenneth Soddy, who will have an office at 19 Manchester Street, London W 1, England. The executive board, which includes representatives of all six continents, consists of Dr. J. D. M. Griffin (Canada), Miss K. Hesselgren (Sweden), Dr. M. K. el Kholy (Egypt), Dr. E. Krapf (Argentina), Dr. K. R. Masani (India), Dr. D. Odum (Great Britain), Dr. Y. Porcher (France), Professor H. Roxo (Brazil), Dr. H. C. Rumke (Holland), Dr. J. Russell (New Zealand), Dr. G. S. Stevenson (United States), and Professor J. Stuchlik (Czechoslovakia). The executive board elected Professor H. C. Rumke of Utrecht as their chairman.

The World Federation offers a means for trans-national collaboration on the problems of mental health. Also, through consultative status with various United Nations agencies, such as the World Health Organization and U. N. E. S. C. O., the World Federation

may be able to provide a channel for two-way communication between the United Nations and the agencies, associations, and professions in different countries.

This is one reason for asking the various professional associations in the United States to become members of this World Federation, as they will soon be invited to do.

For further information address Nina Ridenour, Executive Officer, International Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

AN INTERNATIONAL CONGRESS OF PSYCHIATRY TO BE HELD IN PARIS

An International Congress of Psychiatry will be held in Paris October 4-12, 1950.

In accordance with regulations decided on at the International Preparatory Meeting (Paris, October 23, 1947), the official spoken languages will be English, French, Spanish, and (should Russia participate) Russian.

The program of the six main afternoon sessions includes:

1. *General Psychopathology*. Session's Chairman: Professor Ferdinand Morel, of Geneva, Switzerland. Subject: "Psychopathology of Delusions."
2. *Clinical Psychiatry*. Session's Chairman: Professor Honorio Delgado, of Lima, Peru. Subject: "Application of Testing Methods to Clinical Psychiatry."
3. *Psychiatric Anatomo-Physiology*. Session's Chairman: Professor F. L. Golla, of Bristol, England. Subject: "Cerebral Anatomy and Physiology in the Light of Lobotomy and Topectomies."
4. *Psychiatric Biological Therapy*. Session's Chairman: Professor Jozef Handelsman, of Warsaw, Poland. Subject: "Respective Indications of the Shock-Therapy Methods."
5. *Psychotherapy, Psychoanalysis, Psychosomatic Medicine*. Session's Chairman: Dr. Franz Alexander, of Chicago, U. S. A. Subject: "The Evolution and Present Trends of Psychoanalysis."
6. *Social Psychiatry*. Session's Chairman: Professor Torsten Sjögren, of Stockholm, Sweden. Subject: "The Genetic and Eugenic Aspects of Psychiatry."

In addition, these six sections and the seventh section (*Child Psychiatry*) will organize for the morning sessions a number of meetings, symposia, and work sessions.

The organization committee plans to set up two exhibits in connection with the congress, the first one on "Art and Psychopathology" (apply to Dr. Bessière, Centre Psychiatrique Ste-Anne, 1, rue Cabanis, Paris (XIV°); the second on "History of Psychiatric Progress" (Professor Laignel-Lavastine, 12bis, place Laborde, Paris VIII°).

The French committee was entrusted, at the International Preparatory Meeting, with the organization of the congress. This committee, set up in 1947, is as follows: Honorary Chairman, Professor Pierre Janet (*in memoriam*) and Professor Jean Lhermitte (both of Paris); Chairman, Professor Jean Delay (Paris); Vice Chairmen, Dr. L. Marchand (Paris), Dr. Henri Baruk (Paris), Professor P. Delmas-Marsalet (Bordeaux), and Dr. Georges Heuyer (Paris); General Secretary, Dr. Henri Ey (Paris); and Treasurer, Dr. P. Sivadon (Ville-Evrard, Neuilly-sur-Marne, Seine & Oise).

In each country, a national committee of the congress is being set up. When possible, a chairman, a secretary, and a director are appointed for each section.

General Management: *Dr. Henri Ey*, General Secretary, I, rue Cabanis, Paris XIV°.

PENNSYLVANIA PSYCHIATRIC SOCIETY HOLDS ANNUAL DINNER MEETING

At the Tenth Annual Dinner Meeting of the Pennsylvania Psychiatric Society, which took place at the Barclay, in Philadelphia, October 7, 1948, William C. Menninger, M.D., President of the American Psychiatric Association, spoke on "Psychiatry To-day, and To-morrow."

The following officers were elected to serve for the year 1948-1949: President, Thomas A. Rutherford, M.D., Waymart; President-Elect, Harold L. Mitchell, M.D., Pittsburgh; Secretary-Treasurer, Philip Q. Roche, M.D., Philadelphia.

The society voted unanimously (1) to adopt the resolutions committing the society to approve in principle the proposed new constitution and by-laws of the American Psychiatric Association as published in the *American Journal of Psychiatry*, Vol. 105, pp. 135-145, August, 1948; (2) to make formal application to the Council of the American Psychiatric Association for recognition of the Pennsylvania Psychiatric Society as the district branch society of the American Psychiatric Association for Delaware and Pennsylvania as provided in Article V of the current by-laws of the American Psychiatric Association and in anticipation of the Pennsylvania Psychiatric Society's later becoming the district constituent society of the American Psychiatric Association for Delaware and Pennsylvania under Article 3 of the proposed new constitution of the American Psychiatric Association, if, as, and when the latter constitution and by-laws are formally approved and adopted; and (3) to conduct a mail ballot of all members and fellows of the American Psychiatric Association residing in Delaware and Pennsylvania and eligible to vote on the above matters.

AMERICAN ACADEMY OF NEUROLOGY ESTABLISHED

Arrangement has been made of the establishment of the American Academy of Neurology, whose purpose it is to further and encourage the practice of clinical neurology and to stimulate teaching and research in neurology and allied sciences.

Active membership in the academy is open to every physician who has been certified in neurology or in both neurology and psychiatry. Junior membership is available to physicians who are now engaged in postgraduate studies in neurology or who are awaiting certification in neurology. In addition, there is an associate membership for those who are not certified in neurology, but whose interests are in fields related to neurology. It is hoped that because of the unrestricted membership, this association will be representative of the entire neurological specialty and will offer an organ of expression for many of the younger men in the field. The American Academy of Neurology at present has 500 members. The first business meeting was held in Chicago in June, 1948.

The first scientific meeting will be held at the French Lick Springs Hotel, French Lick Springs, Indiana, on Wednesday, Thursday, and Friday, June 1, 2, and 3, 1949. Dr. Dave B. Ruskin, of the Caro State Hospital, Caro, Michigan, is in charge of the scientific program.

The present executive council consists of Dr. A. B. Baker, of Minneapolis, President; Dr. Pearce Bailey, of Washington, D. C., Vice President; Dr. Joe R. Brown, of Minneapolis, Secretary-Treasurer; and Dr. Frederick Lewey (Philadelphia), Dr. William A. Smith (Atlanta), Dr. J. M. Nielsen (Los Angeles), and Dr. A. L. Sahs (Iowa City), board of trustees. Communications to the academy should be addressed to Dr. Joe R. Brown, 19 Millard Hall, University of Minnesota, Minneapolis 14, Minnesota.

SUCCESSFUL AGING

As a result of the interest evoked by a course of lectures on "Aging Successfully," given by Dr. George Lawton at Town Hall, New York City, in 1946 and 1947, an organization known as the Association for Successful Aging has been formed in New York City, with Dr. Lawton as its president.

The association aims to change community attitudes toward the aging process, to increase community resources for older people, to set up suitable facilities for self-help. It does *not* intend to work for bigger and better pensions, or to affiliate as an organization with any political group. It is interested in successful aging in psychological, social, personal, and public-health terms. It should

be a source of information, a model demonstration of what can be done by communities everywhere. It hopes to be the source in the community of new and workable ideas, of practical procedures that will fit into the general picture of community life, of educational campaigns—not to glorify old age or to give older persons special privileges, economic or otherwise, but to fill the second forty years with as many satisfying, happy, and useful experiences as the first forty.

The association holds ten monthly dinner meetings a year, at which an authority in the field of aging speaks. This is followed by discussion and a business meeting. Membership is open to any man or woman interested, who will pay the \$5.00 annual dues. The ages of members range from twenty-eight to eighty-five, with the average age in the mid-forties. Further details and an application blank can be had by writing to the secretary, Miss Beatrice Blum, 1057 Faile Street, New York 59, N. Y.

ANNUAL CONVENTION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The 1949 convention of the American Occupational Therapy Association will be held at the Book-Cadillac Hotel, in Detroit, Michigan, August 23, 24, and 25. The convention will be followed by an institute on August 26 and 27.

PROGRAM OF THE NATIONAL COMMITTEE ON ALCOHOL HYGIENE

The Scientific Committee of The National Committee on Alcohol Hygiene plans, for the ensuing year, a three-pronged drive aimed at: (1) practically educating and obtaining results in getting general hospitals to accept the fact that the alcoholic is a sick person, and to aid in providing medical help; (2) integrating a training program for medical doctors as directors of community set-ups for alcoholism control; and (3) in the field of prevention, acquainting the senior-high-school and young college students with the medical psychological facts about alcohol, alcoholic beverages, and the alcoholic.

At the October annual meeting of the Committee, the following officers were elected: President, Robert V. Seliger, M.D., chief psychiatrist, Neuropsychiatric Institute of Baltimore, Maryland; Vice President, Lawrence F. Woolley, M.D., psychiatrist, Emory University Hospital and Medical School, Atlanta, Georgia; Secretary-Treasurer, Victoria Cranford, psychotherapist, Neuropsychiatric Institute of Baltimore, Maryland; Assistant Secretary-Treasurer, Caroline Diggs, chief social worker, U. S. Marine Hospital, Baltimore, Maryland.

SPECIAL TWO-WEEK COURSE IN PSYCHOTHERAPEUTIC MEDICINE

Three specially selected groups of army medical officers, consisting of from 20 to 24 men each, drawn from a variety of medical installations and representing a cross-section of the Army Medical Corps, recently completed a special two-week course in psychotherapeutic medicine.

Each of the groups was uniformly enthusiastic about this instruction which, while it was of necessity superficial, nevertheless, to quote one of the students, "opened the door to an entirely new way of thinking."

The results, according to Colonel John M. Caldwell, Jr., Chief of the Neuropsychiatry Consultants Division of the Medical Department, were beyond expectation. So encouraging was the response of the officers that plans are now being made to repeat the course as soon as possible, this time selecting as students chiefs of services and sections.

Designed to teach the principles of psychotherapeutic medicine to non-psychiatrists, the course was conducted simultaneously at three army general hospitals. Dr. Benjamin H. Balser, of New York City, headed the course at Walter Reed, Washington, D. C.; Dr. Jacob E. Finesinger, of Boston, taught at Fitzsimons, Denver, Colorado; and Dr. Lawrence S. Kubie, of New York City, led the instruction at Letterman, San Francisco, California. Each was assisted by a ten-man team composed of civilian psychiatrists, psychologists, and social workers.

The course, which was patterned on the initial 1946 experiment sponsored jointly by the Commonwealth Fund and the University of Minnesota, aimed at five specific goals: defining the patient-physician relationship; establishing the significance of a neurosis; pointing out the need for, and methods of, comprehensive diagnosis and therapy, based on the interrelationship of emotional disturbance and somatic complaints; indicating the usefulness of the interview in both diagnosis and therapy; and providing some knowledge helpful in recognizing more malignant conditions. Throughout the course, major emphasis was placed on the art of medicine, which encompasses the whole man, as opposed to the current trend toward organ diagnosis and fractional therapy—in a word, overspecialization.

Instruction was divided into three main categories—lectures laying the theoretical groundwork for the kind of medical care the students were to learn; seminars for the presentation and discussion of methodology; and clinic sessions, with additional section meetings where students and instructors hammered out the significance of the clinical work case by case.

Concentrated though the instruction essentially was, particularly in the reading matter to be covered, it was received with unflagging attention and enthusiasm by the students. From the point of view of the instructors, who were well aware of the sharp limitations to what psychiatrists can do alone, it was encouraging to discover that men in general practice could learn so much and so readily about ways of helping psychoneurotic patients. They found that, while naturally no firm grasp of any comprehensive theory of human behavior can be acquired in two weeks, the students were at least led to see emotional phenomena in a biological rather than in a moral or a mechanical perspective.

The students themselves found this broad personal approach to diagnosis and therapy both illuminating and profoundly stimulating. Most of them had been aware, even if vaguely, of an existing relationship between personality and somatic illness; all were challenged by this demonstration of psychiatry as a therapeutic element and by the new concepts they had acquired which, they agreed, pointed the way toward better medicine. Their comments following the conclusion of the course, some of which are appended below, are illustrative of their universal reactions. Typical is the statement of one officer: "Although dubious at first, I feel certain now that patients under my care will benefit greatly from what I have learned." It was significant that the officers felt confident of *helping* patients rather than of effecting 100 per cent cures.

Another wrote: "It is my sincerest hope that one day such a course as this will become a requirement for the curricula of all medical schools. With such a thought I am proud to feel that the army appears to be converted and is showing initiative in promulgating the idea."

And again, pointing the effectiveness of the instruction, an officer comments: "I do not believe that any one will leave this course without its leaving a profound effect on him. The result, at least, will be a better patient-doctor relationship."

Finally, lest such enthusiasm seem overdrawn, there is the statement of an initially reluctant student: "Prior to the course I was relatively unaware of the practical applications to which I could put some of the material that has been covered in the course. I must confess that I did not ask to be sent to this course, but was sent. Now I feel very fortunate that I have been able to attend."

NEW YORK UNIVERSITY EXPANDS ITS PSYCHIATRIC AND NEUROLOGIC TEACHING AND RESEARCH PROGRAMS

The New York University is expanding its postgraduate and graduate teaching facilities in psychiatry and neurology. Recently, the

Postgraduate Hospital was amalgamated into the New York University-Bellevue Medical Center. Simultaneously, the New York University announced the formation of a new postgraduate school of medicine, in addition to its already existing college of medicine.

Dr. S. Bernard Wortis, in addition to his present position as professor of psychiatry and Chairman of the Department of Psychiatry in the New York University College of Medicine, has been appointed professor of psychiatry and neurology in the postgraduate medical college and Director of the Psychiatric and Neurologic Services of the New York University Postgraduate Hospital. He has accordingly relinquished administrative responsibility as Director of the Bellevue Psychiatric Division and, on January 1, 1949, became consultant in psychiatry and neurology to the Bellevue Psychiatric Division.

Dr. Lewis I. Sharp, associate professor of clinical psychiatry at New York University, will assume the position of Director of the Bellevue Psychiatric Division. This new arrangement will facilitate the coordination of the postgraduate and undergraduate training and research programs in psychiatry and neurology.

In addition, Dr. Morris Herman, associate professor of psychiatry, has relinquished his position as Assistant Director of the Bellevue Psychiatric Division in order to do full-time psychiatric teaching and research in both the postgraduate and the undergraduate colleges of medicine. He will be visiting psychiatrist and neurologist to the Bellevue Psychiatric Division and will also be on the visiting staff of the University Postgraduate Hospital.

These staff changes will permit an expansion of the New York University-Bellevue Medical Center's comprehensive program for training in psychiatry and neurology in the undergraduate and postgraduate colleges of medicine and their related clinical hospital services.

RESIDENCY TRAINING IN NEUROLOGY OFFERED BY PHILADELPHIA DEANS COMMITTEE

- An additional residency-training program for physicians who desire to train in neurology under the Veterans Administration has been organized by the Philadelphia Deans Committee. This residency covers a period of three years or less, depending upon the previous experience of an applicant, and is designed to prepare residents for certification in neurology for the American Board of Psychiatry and Neurology. The program includes rotation through the Veterans Administration Hospital, Coatesville, Pennsylvania; Veterans Administration Regional Office, Philadelphia, Pennsylvania;

and the Philadelphia General Hospital. Applications should be sent to the Manager, Veterans Administration Hospital, Coatesville, Pennsylvania.

PSYCHIATRIST WANTED FOR CHILD-GUIDANCE CLINIC

A child-guidance clinic under community sponsorship is to be established in the Oranges and Maplewood in New Jersey. It will supplement the work of the Essex County Child Guidance Clinic, whose distinguished director was the late Dr. James S. Plant. The new clinic will emphasize therapy. A child psychiatrist with demonstrated ability in treatment and some experience in a child-guidance clinic is being sought who will serve as medical director. The staff will also include a clinical psychologist, a chief psychiatric social worker, and one or more assistant psychiatric workers.

The clinic will be conducted in close coöperation with the public schools and the social agencies of the community. A mental-hygiene program conducted through parent and teacher conferences and community lectures is also included in the plans for the clinic.

Funds sufficient to insure employment of able and experienced professional leadership for the clinic have been made possible through joint action of the municipal governments of East Orange, Orange, West Orange, South Orange, and Maplewood and by subscription of funds from a private endowment fund for child welfare. The events that led up to the founding of this clinic were popularly described in a *Saturday Evening Post* article (August 7, 1948)—"The Case That Rocked New Jersey." The clinic is independently incorporated and will be administered by an autonomous board.

Further information concerning the clinic can be obtained from the coördinating and planning agency that has sponsored the clinic—the Social Welfare Council of the Oranges and Maplewood, 439 Main Street, Orange, New Jersey.

COSTS OF LONG-TERM MENTAL-HOSPITAL CARE

During 1947, the cost of providing long-term hospital care in mental hospitals was approximately 400 million dollars, according to estimates recently issued by the Mental Hygiene Division of the Public Health Service, Federal Security Agency. Between 1945 and 1947, expenditures for maintenance in hospitals providing long-term care for psychiatric patients increased by \$154,000,000, or nearly 65 per cent of the estimated expenditure for 1945. In terms of the annual cost per patient, or per-capita expenditure, the increase was from \$470 in 1945 to \$731 in 1947, an increase of about 55 per cent.

This increase reflects in large part the increase in the general price level during the period, but may also reflect to some degree improvement in the quality of mental-hospital care during the post-war period.

The estimates presented here are based on figures from a variety of sources. For state, psychopathic, and Veterans Administration neuropsychiatric hospitals, the figures are reasonably complete. For county and city hospitals, and private hospitals, however, the basic data were somewhat fragmentary, and the estimates are in some instances based on the assumption of a constant relationship between annual changes for these two types of hospital, respectively, and corresponding changes for state hospitals.

In view of this situation, estimates of expenditures have been rounded to the nearest million, and those of average daily population, to the nearest thousand.

EXPENDITURE FOR MAINTENANCE IN HOSPITALS FOR THE LONG-TERM CARE OF
PSYCHIATRIC PATIENTS, BY TYPE OF HOSPITAL, FOR THE UNITED
STATES, 1945 TO 1947

<i>Type of hospital and year</i>	<i>Total expenditure for maintenance</i>	<i>Average daily resident- patient population</i>	<i>Per- capita expenditure</i>
<i>1947</i>			
State, county, and city hospitals *....	\$264,000,000	481,000	\$549
Veterans' neuropsychiatric hospitals †..	96,000,000	45,000	2,133
Private hospitals ‡	35,000,000	14,000	2,500
All hospitals	\$395,000,000	540,000	\$731
<i>1946</i>			
State, county, and city hospitals *....	\$206,000,000	468,000	\$440
Veterans' neuropsychiatric hospitals †..	55,000,000	43,000	1,279
Private hospitals ‡	31,000,000	14,000	2,214
All hospitals	\$292,000,000	525,000	\$556
<i>1945</i>			
State, county, and city hospitals *....	\$180,000,000	460,000	\$391
Veterans' neuropsychiatric hospitals †..	33,000,000	39,000	846
Private hospitals ‡	28,000,000	14,000	2,000
All hospitals	\$241,000,000	513,000	\$470

* Based on data from the Annual Census of Patients in Mental Institutions.

† Based on fiscal-year data furnished by the Veterans Administration.

‡ Based on tabulation of data for those hospitals reporting information or operating costs for the American Hospital Association Directory.

SCIENTISTS ANNOUNCE BERNAYS AWARD FOR INTERGROUP
RELATIONS RESEARCH

A new Edward L. Bernays award for the best research on intergroup relations in this country is announced by the Society for the Psychological Study of Social Issues.

According to Professor Ronald Lippitt, president of the society, the Edward L. Bernays Intergroup Relations Award for 1948-49, a \$1,000 United States government bond, will be presented to the individual or group contributing "the best action-related research on some aspect of the problem of improving relations between groups within the United States."

The contest, Professor Lippitt said, is open to all social scientists here and abroad. All research published or completed during 1948 and 1949 will be eligible for the competition, which closes July 1, 1949. Manuscripts reporting completed research, but not yet published, will also be eligible.

The contest will be judged by a committee of judges composed of leading American social scientists. All reports and studies submitted for the award are to be sent in duplicate before the dead line to the chairman of the judges.

Chairman for the Intergroup Relations Award is Professor Gordon Allport, Department of Social Relations, Harvard University. Inquiries about the award should be addressed to Professor Ronald Lippitt, President, Society for the Psychological Study of Social Issues, Research Center for Group Dynamics, University of Michigan, Ann Arbor, Michigan.

The Society for the Psychological Study of Social Issues, which is sponsoring the Bernays Award, consists of more than 800 leading social psychologists, anthropologists, sociologists, and community leaders devoted to the scientific analysis and interpretation of social issues.

The award will be presented to the winner in 1949 at the annual convention of the American Psychological Association, of which the Society for the Psychological Study of Social Issues is a division.

The Intergroup Relations Award for 1948-49 was made possible by a gift to the society by one of its members, Edward L. Bernays.

The first award of this kind sponsored by the society was the Edward L. Bernays Atomic Energy Award for the best action-related research in the social implications of atomic energy. It was presented September 10 at this year's annual convention of the American Psychological Association to Professor Hornell Hart, of Duke University, for his research analysis, *Social Science and the Atomic Crisis*. This developed a plan for a "Manhattan Project"

of social sciences to accelerate research on basic social problems arising from the development of atomic energy.

A condensed report of Professor Hart's project will be published by the Society for the Psychological Study of Social Issues.

SOUTH DAKOTA MENTAL HEALTH ASSOCIATION

The South Dakota Mental Health Association has passed its first milestone, having had its First Annual Meeting on the 13th of October. Officers and a board of directors were elected, and an executive committee is to be chosen by the board at an early date. Mr. K. J. Campbell, of Sioux Falls, is president of the association.

In coöperation with the state board of health, the association is sponsoring the radio series *The Tenth Man* and *For These We Speak*, the former being broadcast now over seven stations in the state.

WANTED: NAMES OF PSYCHIATRISTS WITH INDUSTRIAL EXPERIENCE

The Department of Human Relations at the School of Industrial and Labor Relations at Cornell University is attempting to compile as complete as possible a roster of all psychiatrists who have at any time had industrial experience. Will any psychiatrists who have had such experience please send their names to Dr. Temple Burling, Department of Human Relations, New York State School of Industrial and Labor Relations, Cornell University, Ithaca, New York.

FELLOWSHIPS IN INDUSTRIAL PSYCHIATRY

Dr. Graham Taylor, M.D., McGill University, 1943, with two years of postgraduate work in psychiatry, has begun a fellowship in industrial psychiatry at the New York School of Industrial and Labor Relations. This fellowship is made possible by the Carnegie Foundation, and is a pioneering venture in training in research in the application of psychiatry to industrial problems. Arrangements for next year have not been completed, but it is expected that one or more fellowships can be offered, to begin in September, 1949. Any one interested in being considered for such a fellowship should communicate with Dr. Temple Burling, School of Industrial and Labor Relations, Cornell University, Ithaca, New York.

MENTAL-HOSPITAL CONSULTANT APPOINTED BY PUBLIC HEALTH SERVICE

Appointment of Dr. Riley H. Guthrie as special mental-hospital consultant has been announced by the Mental Hygiene Division of the Public Health Service, Federal Security Agency.

Dr. Guthrie will be available to conduct surveys of mental hospitals and to provide consultative services in hospital administration, care of patients, and other problems of mental hospitals. Requests for his services may be made by state governors, superintendents of state mental hospitals, or other qualified persons concerned with the administration of mental hospitals.

Dr. Guthrie has been associated with state mental hospitals for the past twenty years and has been superintendent of the Norwich State Hospital, Norwich, Connecticut, for the past two years. Before that, he served on the staff of St. Elizabeths Hospital, Washington, D. C.; of Boston Psychopathic Hospital, Boston, Massachusetts; of the Massachusetts Department of Mental Diseases; of Monson State Hospital, Palmer, Massachusetts; of Massillon State Hospital, Massillon, Ohio; and of Arkansas State Hospital, Little Rock, Arkansas.

Dr. Guthrie is a graduate of the University of Arkansas and received his medical degree in 1921 from the University of Tennessee. He is a fellow of the American Medical Association and of the American Psychiatric Association; a diplomate of the American Board of Psychiatry and Neurology; and a member of the New England Society of Psychiatry, of the Massachusetts Psychiatric Society, and of the American Psychopathological Association. He is also the author of numerous articles on nervous and mental disorders.

CURRENT BIBLIOGRAPHY *

Compiled by

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The National Health Library

- Adams, Edward C., M.D.** Problems in attitude therapy in a mental hospital. *American journal of psychiatry*, 105:456-61, December 1948.
- Adamson, John F. and Adamson, W. C., M.D.** Aldarsone therapy in the treatment of general paresis. *Delaware state medical journal*, 20:175-77, August 1948.
- Adler, Morris H., M.D.** Case study of a combat veteran. *Journal of nervous and mental disease*, 108:200-10, September 1948.
- Aita, John A., M.D. and Reitan, R. M.** Psychotic reactions in the late recovery period following brain injury. *American journal of psychiatry*, 105:161-69, September 1948.
- Alcock, Theodora.** Conclusions from psychiatric work with evacuated children. *British journal of medical psychology* (London), 21:181-84, 1948, Part 3.
- Aldrich, Charles A., M.D.** A health plan for all children in a community. *Journal of home economics*, 40:359-60, September 1948.
- Alexander, Leo, M.D.** Sociopsychologic structure of the SS: psychiatric report of the Nurnberg trials for war crimes. *Archives of neurology and psychiatry*, 59:622-34, May 1948.
- Alexander, Leo, M.D.** War crimes and their motivation: the socio-psychological structure of the SS and the criminalization of a society. *Journal of criminal law and criminology*, 39:298-326, September-October 1948.
- Alexander, Leo, M.D.** War crimes: their social-psychological aspects. *American journal of psychiatry*, 105:170-77, September 1948.
- Allen, Frederick H., M.D.** Developments in child psychiatry in the United States. *American journal of public health*, 38:1201-9, September 1948.
- Alper, Benedict S.** Prevention and control of delinquency at the international level. *Focus, National probation and parole association*, 27:171-74, November 1948.
- Amatruda, Catherine S., M.D.** The rôle of developmental diagnosis in pediatrics. *Illinois medical journal*, 94:251-55, October 1948.
- Anderson, Norman S., M.D.** Neuropsychiatric examinations of prisoners at Fort Knox. *Bulletin, U. S. Army medical department*, 8:790-96, October 1948.
- Angus, Leslie R., M.D.** Schizophrenia and schizoid conditions in students in a special school. *American journal of mental deficiency*, 53:227-38, October 1948.
- Angyal, Andras, M.D.** The holistic approach in psychiatry. *American journal of psychiatry*, 105:178-82, September 1948.
- Anonymous.** "I'd try anything—" Survey midmonthly, 84:303-5, October 1948.
- Arief, Alex J., M.D. and Rotman, D. B., M.D.** Psychopathic personality: some social and psychiatric aspects. *Journal of criminal law and criminology*, 39:158-66, July-August 1948.
- Ashley-Montagu, Montague F., M.D.** Human values and family policy. *Marriage and family living*, 10:5, 11, Winter 1948.
- Association for the advancement of psychotherapy.** The psychopathology of comic books. A symposium. *American journal of psychotherapy*, 2:472-90, July 1948.
- Aves, Geraldine M.** Britain improves social services to children. *Child, U. S. Children's bureau*, 13:34-37, September 1948.
- Bacmeister, Rhoda W.** The family comes first. *Childhood education*, 25:8-11, September 1948.
- Bakwin, Ruth M., M.D., Weider, Arthur and Bakwin, Harry, M.D.** Mental testing in children. *Journal of pediatrics*, 33:384-94, September 1948.
- Barker, Wayne, M.D.** Studies in epilepsy: personality pattern, situational stress, and the symptoms of narcolepsy. *Psychosomatic medicine*, 10:193-202, July-August 1948.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

- Barnett, Gordon J.** The truth about aptitude tests. Survey midmonthly, 84:327-29, November 1948.
- Barton, Claribel S.** My sister and I—a case history. Mental hygiene news, New York state department of mental hygiene, 19:3, 10, 12, November 1948.
- Bateman, J. Fremont, M.D. and Dunham, H. W.** The state mental hospital as a specialized community experience. American journal of psychiatry, 105:445-48, December 1948.
- Bauer, William W., M.D.** The inseparables: body and mind. National parent-teacher, 43:4-6, September 1948.
- Beer, Ethel S.** Day nursery or nursery school—which does your child need? Hygeia, 26:732-33, 754-55, October 1948.
- Bell, Bernard I.** Pastoral counseling of university scholars. Journal of pastoral care, 2:1-5, Summer 1948.
- Bellsmith, Ethel B.** Recent developments in treatment in mental hospitals. Journal of psychiatric social work, 18:3-10, Summer 1948.
- Bender, Lauretta, M.D.** Genesis of hostility in children. American journal of psychiatry, 105:241-45, October 1948.
- Benedek, Therese, M.D.** An approach to the study of the diabetic. Psychosomatic medicine, 10:284-87, September-October 1948.
- Benjamin, John D., M.D., Coleman, J. V., M.D. and Hornbein, Ruth.** A study of personality in pulmonary tuberculosis. American journal of orthopsychiatry, 18:704-7, October 1948.
- Bennet, Edward A., M.D.** Psychiatry in India and Pakistan. Mental health, National association for mental health (London), 8:2-5, August 1948.
- Berger, Irving L., M.D.** Psychopathologic attitudes of frustrated previously employed mothers toward their offspring. Journal of nervous and mental disease, 108:241-49, September 1948.
- Bergler, Edmund, M.D.** Disparagement—the unconscious technique of detachment. Diseases of the nervous system, 9:375-77, December 1948.
- Berkowitz, Sidney J.** An approach to the treatment of marital discord. Journal of social casework, 29:355-61, November 1948.
- Bettelheim, Bruno.** Somatic symptoms in superego formation. American journal of orthopsychiatry, 18:649-58, October 1948.
- Bice, Harry V.** Certain recent theoretical observations and their practical application in a case of feeble-mindedness. American journal of mental deficiency, 53:338-44, October 1948.
- Bice, Harry V.** A decade of psychology: a review based on reports in the American journal of mental deficiency. American journal of mental deficiency, 53:57-66, July 1948.
- Binger, Carl A. L., M.D.** Psychological pneumonia in cardiac patients. Bulletin, New York academy of medicine, 24:687-701, November 1948.
- Bingham, Charles T., M.D.** Psychosomatic medicine: the etiological approach to diagnosis and therapy. Connecticut state medical journal, 12:545-49, June 1948.
- Bird, Brian, M.D.** We cannot make hospitals out of asylums. Modern hospital, 71:65-67, September 1948.
- Bird, H. W., M.D.** Varying hypnotizability in a case of Parkinsonism. Bulletin, Menninger clinic, 12:210-17, November 1948.
- Black, Algernon D.** Can we educate for maturity? Child study, 25:105-6, 123, Fall 1948.
- Blackman, Nathan, M.D.** Pseudomaturity—an aftermath of military service. The rôle of group psychotherapy in its treatment. Diseases of the nervous system, 9:370-74, December 1948.
- Blain, Daniel, M.D.** Importance of adult psychiatric out-patient clinics to mental health and the community. Mental hygiene bulletin, Michigan society for mental hygiene, 6:1-6, November 1948.
- Blake, Marilyn A.** Probation is not casework. Federal probation, 12:54-57, June 1948.
- Blazer, Alfred, M.D.** Backache as a psychosomatic problem. American journal of psychotherapy, 2:441-47, July 1948.
- Bloomberg, Wilfred.** Plan for screening, induction, and utilization of man power. American journal of psychiatry, 105:462-65, December 1948.
- Bloomberg, Wilfred, M.D. and others.** An intensive neuropsychiatric treatment program in a veterans hospital. American journal of psychiatry, 105:204-10, September 1948.
- Blue, John T., Jr.** The relationship of juvenile delinquency, race, and economic status. Journal of Negro education, 17:469-77, Fall 1948.
- Boisen, Anton T.** The service of worship in a mental hospital: its therapeutic significance. Journal of clinical pastoral work, 1:19-25, Summer 1948.

- Boldt, Waldemar H., M.D.** Postnatal cerebral trauma as an etiological factor in mental deficiency. *American journal of mental deficiency*, 53: 247-67, October 1948.
- Boltz, Oswald H., M.D.** A report of spontaneous recovery in two cases of advanced schizophrenic organismic stagnation. *American journal of psychiatry*, 105: 339-45, November 1948.
- Bornstein, Berta.** Emotional barriers in the understanding and treatment of young children. *American journal of orthopsychiatry*, 18:691-97, October 1948.
- Bowers, John Z., M.D.** Atomic energy in medicine. *American journal of psychiatry*, 105:321-28, November 1948.
- Braislin, Doris.** Emotional life, physical health, external behavior. *Hearing news*, American hearing society, 16:5, 18, 20, 22, November 1948.
- Braude, J. M.** Boys' court: individualized justice for the youthful offender. *Federal probation*, 12:9-14, June 1948.
- Breitbart, Sara, M.D.** "Hedda Gabler," a critical analysis. *American journal of psychoanalysis*, 8:55-58, 1948, No. 1.
- Brickman, William W.** Juvenile delinquency. *School and society*, 68: 305-11, October 30, 1948.
- Brody, Eugene B., M.D.** Psychiatric problems of the German occupation. *American journal of psychiatry*, 105: 286-91, October 1948.
- Brozek, Josef and Schiele, B.C., M.D.** Clinical significance of the Minnesota multiphasic F scale evaluated in experimental neurosis. *American journal of psychiatry*, 105:259-66, October 1948.
- Bruch, Hilde, M.D. and McCune, D. J., M.D.** Psychotherapeutic aspects of pediatric practice. *Pediatrics*, 2: 405-9, October 1948.
- Bruder, Ernest E.** A clinically trained religious ministry in the mental hospital. *Journal of clinical pastoral work*, 1:26-35, Summer 1948.
- Bunker, Henry A., M.D.** Note on an 'ambivalent' dream. *Psychoanalytic quarterly*, 17:389-90, July 1948.
- Burchard, Edward M. L., Michaels, J. J., M.D. and Kotkov, Benjamin.** Criteria for the evaluation of group therapy. *Psychosomatic medicine*, 10:257-74, September-October 1948.
- Burlingame, Clarence C., M.D.** Is there mental disease per se? *Journal of the Missouri state medical association*, 45:742-44, 747, October 1948.
- Burlingame, Clarence C., M.D.** What is mental disease? *Connecticut state medical journal*, 12:721-25, August 1948.
- Butler, Fred O., M.D.** California's legal approach and progress in the rehabilitation of the defective and psychopathic delinquent. *American journal of mental deficiency*, 53: 76-79, July 1948.
- Cameron, Donald E., M.D.** Anxiety states. *Canadian medical association journal* (Montreal), 59:307-10, October 1948.
- Cason, Hulsey.** The characteristics of the psychopath. *American journal of psychiatry*, 105:211-19, September 1948.
- Chance, Erika.** Group psychotherapy and the psychiatric social worker. *Mental health*, National association for mental health (London), 8:8-12, August 1948.
- Child study association of America.** The meaning and management of aggression in children. *Child study*, 26:7-8, 28-29, Winter 1948-49.
- Children need continuity—Symposium.** *Childhood education*, 25:99-131, November 1948.
- Chisholm, Brock, M.D.** Our biggest business—the nurture of the children. *Childhood education*, 25:4-7, September 1948.
- Chittenden, Gertrude E., Neabitt, Margaret, and Williams, Betsey.** The nursery school in American education today. *Understanding the child*, 17: 107-10, October 1948.
- Clardy, Ed. R., M.D.** Dealing with behavior problems and mental disorders of school children. *Journal of school health*, 18:203-9, October 1948.
- Clarke, Robert B., M.D., Raphael Theophile, M.D. and Westerberg, M. R., M.D.** Neurologic findings among college students. *Journal-Lancet*, 68:398-400, October 1948.
- Cochrane, Hortense S.** Emotional aspects of social adjustment for the child. *Mental hygiene*, 32:586-95, October 1948.
- Coleman, Jules V., M.D.** The child-guidance clinic and community mental-health programs. *Mental hygiene*, 32:539-48, October 1948.
- Coleman, Jules V., M.D., Short, G. B. and Hirschberg, J. C., M.D.** The intake interview as the beginning of psychiatric treatment in children's cases. *American journal of psychiatry*, 105:183-86, September 1948.
- Corbett, Kay.** A way to better parenthood. *Parents' magazine*, 23:23, 94, 96, 98, October 1948.
- The Cornelian corner commission for the international mental health con-**

- gress: a summary. Mental hygiene bulletin, Michigan society for mental hygiene, 6:6-8, August 1948.
- Corwin, Edward H. L.** Institutional facilities for the treatment of alcoholism. *Hygeia*, 26:786-87, 822, November 1948.
- Cotzin, Milton.** Group psychotherapy with mentally defective problem boys. *American journal of mental deficiency*, 53:268-83, October 1948.
- Crandell, Archie, M.D.** The effect of neurosurgical procedures on certain psychiatric disorders. *Journal of the Medical society of New Jersey*, 45: 480-83, October 1948.
- Creak, Eleanor M., M.D.** Parent-child relationship in C. P. Spastic review, 9:4-5, December 1948.
- Crutcher, Hester B.** Family care of mental defectives. *American journal of mental deficiency*, 53:345-52, October 1948.
- Cunningham, James M., M.D.** Psychiatric case work as an epidemiological tool. *American journal of orthopsychiatry*, 18:659-69, October 1948.
- Curry, Manfred.** The relationship of weather conditions, facial characteristics and crime. *Journal of criminal law and criminology*, 39:253-61, July-August 1948.
- Cutts, Norma E. and Moseley, Nicholas.** Mental health is no mystery. *NEA journal, National education association*, 37:525-26, November 1948.
- Dahlberg, Gunnar, M.D.** A new method in crime statistics applied to the population of Sweden. *Journal of criminal law and criminology*, 39: 327-41, September-October 1948.
- Daniels, George E., M.D.** The rôle of emotion in the onset and course of diabetes. *Psychosomatic medicine*, 10:288-90, September-October 1948.
- Darke, Roy A., M.D. and Geil, G. A.** Homosexual activity: relation of degree and rôle to the Goodenough test and to the Cornell selectee index. *Journal of nervous and mental disease*, 108:217-40, September 1948.
- Davidson, Henry A., M.D.** The psychiatric manpower of New Jersey. *American journal of psychiatry*, 105: 292-97, October 1948.
- Davis, Harriet E.** Hate in fancy clothes. A digest by Harriet Eager Davis of a lecture by Jule Eisenbud, M.D. *Child study*, 26:3-4, 22-23, Winter 1948-49.
- Davis, Harriet E.** Where aggressions begin. *Independent woman*, 27: 223-24, August 1948.
- Davis, Marilyn P.** The "rooming in" plan. *Hygeia*, 26:784-85, 827-28, November 1948.
- Day, Florence R.** Current developments in the graduate curriculum. *Journal of social casework*, 29:335-42, November 1948.
- DeProspero, Chris J., Rosenzweig, L. E. and Shainman, Leo.** A follow-up program for the mentally retarded. *American journal of mental deficiency*, 53:353-62, October 1948.
- Deutsch, Albert.** A way to better public relations. *Journal of psychiatric social work*, 18:24-29, Summer 1948.
- DeWitt, Henrietta B.** The function of the social worker in the total treatment program in a state mental hospital. *American journal of psychiatry*, 105:298-303, October 1948.
- Dicks, Russell L.** The interpersonal relationship. *Journal of pastoral care*, 2:16-18, Summer 1948.
- Dicks, Russell L.** The pastor's use of creative listening. *Mental hygiene*, 32:578-85, October 1948.
- Dicks, Russell L.** The spiritual care of the sick. *Modern hospital*, 71: 81-82, September 1948.
- Dimchevsky, Esther M.** Counseling in emotional problems. *Mental hygiene*, 32:549-59, October 1948.
- Dooner, Mary A.** Assisting in electric shock treatment. *Public health nursing*, 40:561-62, November 1948.
- Dotson, George E.** The importance of education for family life. *Understanding the child*, 17:99-101, October 1948.
- Dufault, Paul, M.D.** TB patients are people. *Bulletin, National tuberculosis association*, 34:123-24, September 1948.
- Eames, Thomas H., M.D.** Incidence of diseases among reading failures and nonfailures. *Journal of pediatrics*, 33:614-17, November 1948.
- Ehrensweig, Anton.** Unconscious formation in art. *British journal of medical psychology (London)*, 21: 185-214, 1948, Part 3.
- Eliasberg, Wladimir, M.D.** Psychiatric and psychologic opinions in court. *Journal of criminal law and criminology*, 39:152-57, July-August 1948.
- Eliot, Martha M., M.D. and Faegre, M. L.** Does America care for its children? *Childhood education*, 25: 17-21, September 1948.
- Engberg, Edward J., M.D.** A survey of papers presented to the Association on mental deficiency in the past ten years dealing with administration. *American journal of mental deficiency*, 53:24-46, July 1948.
- English, Oliver S., M.D.** Psychosomatic medicine; clinical and research implications. *Mental hygiene*, 32:560-67, October 1948.

- English, Oliver S., M.D. and Foster, C. J. How to raise better husbands. Parents' magazine, 23:22, 110-13, November 1948.
- English, Oliver S., M.D. and Foster, C.J. What parents can learn from the Kinsey report. Parents' magazine, 23:27, 144-48, October 1948.
- An evaluation of selected educational films in the field of mental hygiene. Mental hygiene news, New York state department of mental hygiene, 19:4, 11, October 1948.
- Fabing, Howard D., M.D. Combined coramine-electroshock therapy in the treatment of psychotic excitement. American journal of psychiatry, 105:435-38, December 1948.
- Farrell, Malcolm J., M.D., Brazier, M. F. and Shea, J. T., M.D. A day class for community pupils in an institution for the mentally retarded. American journal of mental deficiency, 53:187-92, October 1948.
- Feldman, Sander S., M.D. Mannerisms of speech: a contribution to the working through process. Psychoanalytic quarterly, 17:356-67, July 1948.
- Felix, Robert H., M.D. Mental hygiene and public health. American journal of orthopsychiatry, 18:679-84, October 1948.
- Fetterman, Joseph L., M.D. and Victoroff, V. M., M.D. Practical aspects of Mesantoin therapy in epilepsy. American journal of psychiatry, 105:410-16, December 1948.
- Ficarra, Bernard J., M.D. The mental attitude of the cancer patient to his disease. American journal of psychiatry, 105:304-5, October 1948.
- Finesinger, Jacob E., M.D. Psychiatric interviewing. I. Some principles and procedures in insight therapy. American journal of psychiatry, 105:187-95, September 1948.
- Fink, R. M. Teaching mental health in our schools. Better health, North Carolina social hygiene society, 2:6, September 1948.
- Fischer, Siegfried, M.D. Remarks on some basic problems of dynamic psychopathology. American journal of psychotherapy, 2:366-71, July 1948.
- Fiske, Arthur W. A mental hygiene program for Ohio. Mental health and our community, Cleveland mental hygiene association, p. 1, 4, December 1948.
- Flesch, Regina. Treatment goals and techniques in marital discord. Journal of social casework, 29:382-88, December 1948.
- Fontes, Vitor M., M.D. Child health services in Portugal. Mental health, National association for mental health (London), 8:5-8, August 1948.
- Frank, Josette. Books and children's emotions. Child study, 26:5-6, 24-26, Winter 1948-49.
- Frank, Lawrence K. International congress on mental health meets in London. Child, U. S. Children's bureau, 13:50-52, 62, October 1948.
- Frank, Lawrence K. A national policy for the family. Marriage and family living, 10:1-4, Winter 1948.
- Fremont-Smith, Frank, M.D. and Britt, George. World citizenship: the goal for which social scientists joined hands—a hopeful report on Mental health congress in London. Survey graphic, 37:416-18, 437-38, October 1948.
- Freyhan, Fritz A., M.D. The psychosomatic dilemma. Delaware state medical journal, 20:165-68, August 1948.
- Fried, Ralph, M.D. and Mayer, M. F. Socio-emotional factors accounting for growth failure in children living in an institution. Journal of pediatrics, 33:444-56, October 1948.
- Fromm-Reichmann, Frieda, M.D. Notes on the development of treatment of schizophrenics of psychoanalytic psychotherapy. Psychiatry, 11:263-73, August 1948.
- Fry, Clements C., M.D. Drinking in college. Hygeia, 26:710-11, 748, October 1948.
- Fuller, Elizabeth M. Injury-prone children. American journal of orthopsychiatry, 18:708-23, October 1948.
- Galdston, Iago, M.D. A medical and social critique of delinquency. Mental hygiene, 32:529-38, October 1948.
- Gallinek, Alfred, M.D. The nature of affective and paranoid disorders during the senium in the light of electric convulsive therapy. Journal of nervous and mental disease, 108:293-303, October 1948.
- Gauss, Harry, M.D. Stomach ulcers. Hygeia, 26:715-16, 744-46, October 1948.
- Gegenheimer, Ruth A. A quarter century of community supervision of mentally deficient patients. American journal of mental deficiency, 53:92-102, July 1948.
- Gesell, Arnold, M.D. Developmental diagnosis and guidance for the palsied child. Physical therapy review, 28:128-29, May-June 1948.
- Gilbert, Ruth. Preparation for mental hygiene aspects of nursing. Public health nursing, 40:470-77, September 1948.
- Gildea, Edwin F., M.D. Biochemical research in psychiatry. American

- journal of psychiatry, 105:308-10, October 1948.
- Goldhamer, Herbert.** Recent developments in personality studies. American sociological review, 13:555-65, October 1948.
- Goldstein, Irwin.** Implications of mental deficiency. American journal of mental deficiency, 53:207-26, October 1948.
- Gordon, Alfred, M.D.** Fugues in the preadolescent period of life. Medical times, 76:388-90, 397, September 1948.
- Gordon, Alfred, M.D.** Prognostic significance of incidental acute somatic disorders in the course of psychoses: reevaluation of five cases fourteen years later. Archives of neurology and psychiatry, 59:646-52, May 1948.
- Gordon, Gerhart J., M.D.** The problem of psychiatric etiology. Delaware state medical journal, 20:163-65, August 1948.
- Gordon, Hirsch L., M.D.** Fifty shock therapy theories. Military surgeon, 103:397-401, November 1948.
- Gough, Harrison G.** A new dimension of status. I. Development of a personality scale. American sociological review, 13:401-9, August 1948.
- Graves, Charles C., M.D.** Factors in the development and growth of children's personalities. Journal of the Iowa state medical society, 38:437-39, October 1948.
- Greenacre, Phyllis, M.D.** Anatomical structure and superego development. American journal of orthopsychiatry, 18:636-48, October 1948.
- Greenhill, Maurice H., M.D.** Peptic ulcer as a psychosomatic problem. North Carolina medical journal, 9: 499-503, October 1948.
- Greenhill, Maurice H., M.D.** Synopsis of neuropsychiatry for rehabilitation purposes. Journal of rehabilitation, 14:23-27, October 1948.
- Gregory, Doris H.** To love means to understand. Parents' magazine, 23: 33, 82-83, December 1948.
- Greving, Frank T.** A mental-hygiene approach to the integration of a multi-function social-service agency. Mental hygiene, 32:605-24, October 1948.
- Griffith, Francis.** Does your child stutter? Hygeia, 26:728-29, 738-39, October 1948.
- Grinker, Roy R., M.D. and Meyers, Russell, M.D.** Semantics in psychiatry. ETC: a review of general semantics, 6:39-55, Autumn 1948.
- Grotjahn, Martin, M.D.** Transvestite fantasy expressed in a drawing. Psychoanalytic quarterly, 17:340-45, July 1948.
- Gruenberg, Sidonie M.** Learning to decide. National parent-teacher, 43: 7-9, September 1948.
- Guertin, Wilson H.** Mental hygiene: a new frontier in education. Elementary school journal, 49:93-97, October 1948.
- Guttmacher, Manfred S., M.D.** Criminal responsibility. Bulletin, U. S. Army medical department, 8:681-94, September 1948.
- Haiman, Julius A., M.D.** The psychosomatic approach to the treatment of allergy, bronchial asthma, and systemic disorders. Medical record, 161:467-73, September 1948.
- Haines, William H., M.D. and Hoffman, H. R., M.D. and Esser, R. A. M.D.** Commitments under the criminal sexual psychopath law in the criminal court of Cook County, Illinois. American journal of psychiatry, 105: 420-25, December 1948.
- Hales, William M. and Simon, Werner, M.D.** Minnesota multiphasic personality inventory patterns before and after insulin shock therapy: a preliminary report. American journal of psychiatry, 105:254-58, October 1948.
- Hamilton, Donald M., M.D.** Character development of the girl from seven to fourteen. Mental hygiene, 32: 568-77, October 1948.
- Hamilton, Donald M., M.D. and Wall, J.H., M.D.** The hospital treatment of dementia praecox. American journal of psychiatry, 105:346-52, November 1948.
- Hamilton, Gordon.** Helping people—the growth of a profession. Journal of social casework, 29:291-99, October 1948.
- Hannay, Lillian B.** Social neglect: a study of two families. Delaware state medical journal, 20:179-82, August 1948.
- Harms, Ernest.** Training for teachers of mentally handicapped children. School and society, 68:289-92, October 30, 1948.
- Harris, Harold J., M.D.** Psychologic studies as aids in differential diagnosis of brucellosis and psychoneurosis. Diseases of the nervous system, 9:364-69, December 1948.
- Harris, Irving, M.D.** Observations concerning typical anxiety dreams. Psychiatry, 11:301-9, August 1948.
- Harrison, Forrest M., M.D.** Psychophysical unit. Delaware state medical journal, 20:156-59, August 1948.
- Hartmann, Heinz, M.D.** Comments on the psychoanalytic theory of in-

- stinctual drives. *Psychoanalytic quarterly*, 17:368-88, July 1948.
- Hastings, Donald W., M.D.** The psychiatrist and the clergyman. *Northwest medicine*, 47:644-47, September 1948.
- Heckman, A. A.** Measuring the effectiveness of agency services. *Journal of social casework*, 29:394-99, December 1948.
- Henry, Jules.** Common problems of research in anthropology and psychiatry. *American journal of orthopsychiatry*, 18:698-703, October 1948.
- Hicks, Samuel.** The school's part in dealing with behavior problems and mental disorders of school children. *Journal of school health*, 18:210-13, October 1948.
- Hill, Helen F.** Résumé of papers published in the American journal of mental deficiency on social problems dealing with the mentally deficient—1938-1948. *American journal of mental deficiency*, 53:67-75, July 1948.
- Hill, Lee F., M.D.** Preventive pediatrics—behavior aspects. *Rocky Mountain medical journal*, 45:755-62, September 1948.
- Hoffman, Julius.** The care and management of the suicidal patient. *Bulletin, U. S. Army medical department*, 8:888-91, November 1948.
- Hollender, Marc H., M.D.** A psychosomatic approach to vasomotor rhinitis. *American journal of the medical sciences*, 216:476-79, October 1948.
- Horney, Karen, M.D.** The value of vindictiveness. *American journal of psychoanalysis*, 8:3-12, 1948, No. 1.
- Houwink, Eda.** Color is an additional problem. *Mental hygiene*, 32:596-604, October 1948.
- Hunt, Howard F. and others.** A study of the differential diagnostic efficiency of the Minnesota multiphasic personality inventory. *Journal of consulting psychology*, 12:331-36, September-October 1948.
- Hunt, J. McV.** Measuring movement in casework. *Journal of social casework*, 29:343-51, November 1948.
- International congress on mental health.** *British medical journal* (London), p. 395-96, August 21, 1948; p. 433-37, August 28, 1948.
- International congress on mental health.** *Lancet* (London), 255:301-4, August 21, 1948.
- International congress on mental health.** London, August, 1948; statement by International preparatory commission. *Psychiatry*, 11:235-61, August 1948.
- Ivimey, Muriel, M.D.** Negative therapeutic reaction. *American journal of psychoanalysis*, 8:24-33, 1948, No. 1.
- Jenkins, Gladys G.** Does punishment work? *Parents' magazine*, 23:28-29, 50, 52, 54, November 1948.
- Jenkins, Gladys G.** Growing from two to five. *Parents' magazine*, 23:24-25, 60, 62, 64-65, October 1948.
- Joint committee of the British medical association and the Magistrate's association.** *Enuresis.* Medical officer (London), 80:79-81, August 21, 1948.
- Josselyn, Irene M., M.D.** The caseworker as therapist. *Journal of social casework*, 29:351-55, November 1948.
- Kaldeck, Rudolph, M.D. and others.** Physical risks of electroconvulsive therapy. *New England journal of medicine*, 239:773-79, November 18, 1948.
- Kalinowsky, Lothar B. M.D. and Scarfi, J. E., M.D.** The selection of psychiatric cases for prefrontal lobotomy. *American journal of psychiatry*, 105:81-85, August 1948.
- Kaplan, Lillian P. and Livermore, J. B.** Treatment of two patients with punishing superegos. *Journal of social casework*, 29:310-16, October 1948.
- Karpman, Benjamin, M.D.** Emotional background of white slavery: toward the psychogenesis of so-called psychopathic behavior. *Journal of criminal law and criminology*, 39:1-18, May-June 1948.
- Keep, J. L.** When glasses are not enough. *Hygeia*, 26:888-89, 913, December 1948.
- Keliher, Alice V.** Personality for democracy. *NEA journal, National education association*, 37:496-97, November 1948.
- Kelly, Elizabeth M.** A family living course for mentally retarded girls at the pre-vocational school for girls, Newark, New Jersey. *American journal of mental deficiency*, 53:193-98, October 1948.
- Kelly, Herbert T., M.D.** Psychosomatic aspects of physical medicine. *Physical therapy review*, 28:280-83, November-December 1948.
- Kelman, Harold, M.D.** Group therapy: a psychoanalytic viewpoint. *American journal of psychoanalysis*, 8:44-54, 1948, No. 1.
- Kershaw, John D., M.D. and Fisher, Mary.** Discussion on the influence of the parent on the health and well-being of the child. *Journal of the Royal sanitary institute* (London), 68:431-44, September 1948.
- Keyes, Baldwin L., M.D., Bookhammer,**

- R. S., M.D. and Kaplan, A. J., M.D.** Psychiatry in the general hospital. *American journal of psychiatry*, 105: 90-95, August 1948.
- Kieve, Rudolph, M.D.** Some principles of rural psychiatry. *Bulletin of the Menninger clinic*, 12:158-65, September 1948.
- Kilpatrick, Elizabeth, M.D.** A psychoanalytic understanding of suicide. *American journal of psychoanalysis*, 8:13-23, 1948, No. 1.
- Kimball, Lenore.** When does psychiatric teaching begin? *American journal of nursing*, 48:576-77, September 1948.
- The Kinsey report: book review and roundup of opinion.** *American journal of psychotherapy*, 2:398-416, July 1948.
- Kirk, Samuel A.** An evaluation of the study of Bernardine G. Schmidt. *Journal of exceptional children*, 15: 34-40, 54, November 1948.
- Kline, Draza and Overstreet, H. M.** Maintaining foster-homes through case-work skills. *Social service review*, 22:324-39, September 1948.
- Knapp, Peter H., M.D.** Emotional aspects of hearing loss. *Psychosomatic medicine*, 10:203-22, July-August 1948.
- Koch, Edward J., M.D.** Cross section and long section in psychosis: some specific implications of each. *Delaware state medical journal*, 20:159-63, August 1948.
- Koch, Edward J., Jr., M.D.** Physical and mental process disease—an analogy. *Journal of nervous and mental disease*, 108:187-99, September 1948.
- Koontz, Amos R., M.D.** Psychiatry in the next war: shall we again waste manpower? *Military surgeon*, 103: 197-202, September 1948.
- Kreisler, Oscar, M.D., Liebert, Erich, M.D. and Horwitt, M. K.** Psychiatric observations on induced vitamin B complex deficiency in psychotic patients. *American journal of psychiatry*, 105:107-10, August 1948.
- Kris, Ernst.** On psychoanalysis and education. *American journal of orthopsychiatry*, 18:622-35, October 1948.
- Krise, Mary W., Sister, and Roth, M. J., Sister.** Group dynamics and the mentally ill. *Hospital progress*, 29: 384-87, November 1948.
- Landis, Judson T.** An evaluation of marriage education. *Marriage and family living*, 10:81-84, 100-1, Fall 1948.
- Landis, Paul H.** Training teachers for family life education in high schools. *Marriage and family living*, 10:88-89, 95, Fall 1948.
- Lane, Howard.** To make life good. *Childhood education*, 25:12-16, September 1948.
- Langdon-Davies, John.** Epilepsy as a social problem. *Health education journal*, Central council for health education (London), 6:155-59, October 1948.
- Langford, William S. M.D.** Physical illness and convalescence: their meaning to the child. *Journal of pediatrics*, 33:242-50, August 1948.
- Lanzer, Irving A.** Forensic social case work: an analytical survey. *Journal of criminal law and criminology*, 39: 34-48, May-June 1948.
- Lemkau, Paul V., M.D.** Opportunities for mental hygiene in public health. *American journal of orthopsychiatry*, 18:670-78, October 1948.
- Lennox, William G., M.D., McBride, Merle and Potter, Gertrude.** The higher education of epileptics. *Journal of health and physical education*, 19:597-98, 626-27, November 1948.
- Levin, A. J.** The (Edipus myth in history and psychiatry: a new interpretation. *Psychiatry*, 11:283-99, August 1948.
- Levin, Sidney, M.D.** Electroencephalogram in postencephalitic behavior disorder and postencephalitic Parkinsonism. *American journal of psychiatry*, 105:439-42, December 1948.
- Levine, Julius, M.D., Rinkel, Max, M.D. and Greenblatt, Milton, M.D.** Psychological and physiological effects of intravenous pervitin. *American journal of psychiatry*, 105:429-34, December 1948.
- Levine, Sinclair S., M.D.** Early treatment of mentally ill in rehabilitation as viewed by the general physician. *Connecticut state medical journal*, 12:615-19, July 1948.
- Levy, Sol, M.D. and Perry, H. A., M.D.** The rôle of maternal illness during pregnancy in the etiology of Mongolism. *American journal of mental deficiency*, 53:284-93, October 1948.
- Lindner, Robert.** Crime and the child. *Focus, National probation and parole association*, 27:142-46, September 1948.
- Lippman, Hyman S., M.D.** The rôle of the probation officer in the treatment of delinquency in children. *Federal probation*, 12:36-39, June 1948.
- Liston, Sara M., Potgieter, Martha, and Dayton, N. A., M.D.** Nutritional ade-

- quacy of meals served in a state training school for mental defectives. *American journal of mental deficiency*, 53:153-64, October 1948.
- Lorand, Sandor, M.D.** The psychoanalytic contribution to the treatment of behavior problems in children. *American journal of psychiatry*, 105: 357-60, November 1948.
- Lovell, Harold W., M.D.** Electric shock therapy in the aging. *Geriatrics*, 3:285-93, September-October 1948.
- Lowenberg, Miriam E.** A community program for child development. *Childhood education*, 25:22-27, September 1948.
- Lowenberg, Miriam E.** Something new in baby feeding. *Parents' magazine*, 23:28, 149-51, 167, October 1948.
- Lowrie, Samuel H.** Dating, a neglected field of study. *Marriage and family living*, 10:90-91, 95, Fall 1948.
- Luchins, Abraham S.** Specialized audio-aids in a group psychotherapy program for psychotics. *Journal of consulting psychology*, 12:313-20, September-October 1948.
- Lukas, Edwin J.** Crime prevention: who prevents what? *Federal probation*, 12:19-23, June 1948.
- Lussheimer, Paul, M.D.** Environmental influences on the analytic situation. *American journal of psychoanalysis*, 8:34-43, 1948, No. 1.
- McCuskey, Dorothy.** Human relationships in teaching. *NEA journal*. National education association, 37: 504-5, November 1948.
- McDowell, Mehl, M.D.** An abrupt cessation of major neurotic symptoms following an hypnotically induced artificial conflict. *Bulletin of the Menninger clinic*, 12:168-77, September 1948.
- Mace, David R. and others.** World plans for the family. A symposium. *Marriage and family living*, 10:6-11, Winter 1948.
- Maier, Norman R. F.** Experimentally induced abnormal behavior. *Scientific monthly*, 67:210-16, September 1948.
- Malamud, N., M.D.** Fatalities resulting from treatment with subshock doses of insulin. *American journal of psychiatry*, 105:373-76, November 1948.
- Mallinson, Sir William P.** Out-patient electric convulsion treatment. *British medical journal* (London), p. 641-45, October 2, 1948.
- Malzberg, Benjamin.** Ex-service patients admitted to hospitals for mental disease in N. Y. state, 1946-47. *Mental hygiene news*, New York state department of mental hygiene, 19:9, 11, September 1948.
- Malzberg, Benjamin.** A world survey of facilities for the institutional care of mental defectives. *American journal of mental deficiency*, 53:119-27, July 1948.
- Mangus, A. R.** Personality adjustment of rural and urban children. *American sociological review*, 13: 566-75, October 1948.
- Manson, Morse P.** A psychometric differentiation of alcoholics from non-alcoholics. *Quarterly journal of studies on alcohol*, 9:175-206, September 1948.
- Marks, Marjorie F.** Delinquent in diapers. *Hygeia*, 26:880-81, 906, December 1948.
- Martin, Peter A., M.D.** The Rochester plan; a community mental health program. *Mental hygiene bulletin*, Michigan society for mental hygiene, 6:14-16, November 1948.
- Masland, Richard L., M.D.** Epileptic seizures easily confused with functional mental disorders. *North Carolina medical journal*, 9:448-52, September 1948.
- Maslen, Sydney.** Housing and juvenile delinquency. *Federal probation*, 12: 40-44, June 1948.
- Mathies, Lorraine.** Don't ignore rules of mental hygiene. *Library journal*, 73:1239-40, 1267, September 15, 1948.
- Maupin, Robert E., M.D.** Conclusions from fifty years' experience in the treatment of alcoholics. *Industrial medicine*, 17:344-46, September 1948.
- Mayer-Gross, Willy, M.D.** Mental health survey in a rural area: a preliminary report. *Eugenics review* (London), 40:140-48, October 1948.
- Meeker, Ben.** Probation is casework. *Federal probation*, 12:51-54, June 1948.
- Mendoza, Belen T., M.D.** Constitutional study. *Delaware state medical journal*, 20:173-75, August 1948.
- Mental health: international and domestic.** *Lancet* (London), 255: 335-36, August 28, 1948.
- The mental health of mankind.** *Lancet* (London), 255: 298, August 21, 1948.
- Mental hygiene and world peace.** *British medical journal* (London), p. 432, August 28, 1948.
- Meyers, Russell, M.D.** The nervous system and general semantics. II. 'Reality' and 'unreality'. ETC.: a review of general semantics, 6:27-38, Autumn 1948.
- Millar, William M., M.D.** Personality studies of medical students. *Lancet*

- (London), 255:327-31, August 28, 1948.
- Miller, Gertrude E.** Neuropsychiatric food service today. *Journal of the American dietetic association*, 24: 874, 876, 878, October 1948.
- Miller, Hyman, M.D. and Baruch, D. W.** Psychosomatic studies of children with allergic manifestations. I. Maternal rejection; a study of sixty-three cases. *Psychosomatic medicine*, 10:275-78, September-October 1948.
- Miller, James G., M.D.** The mutual dependency of professional training in psychology and psychiatry. *American journal of psychiatry*, 105:116-23, August 1948.
- Miller, Milton L., M.D.** Ego functioning in two types of dreams. *Psychoanalytic quarterly*, 17:346-55, July 1948.
- Miner, Genevieve F.** Techniques of mutual evaluation. *Journal of social casework*, 29:400-3, December 1948.
- Mirsky, Isadore A., M.D.** Emotional factors in the patient with diabetes mellitus. *Bulletin, Menninger clinic*, 12:187-94, November 1948.
- Modlin, Herbert C., M.D.** Ulcer, phobia and narcolepsy: a case report. *Bulletin, Menninger clinic*, 12:203-9, November 1948.
- Mohr, George J., M.D.** Psychiatric problems of adolescence. *Journal of the American medical association*, 137:1589-92, August 28, 1948.
- Money-Kyrle, Roger E.** Social conflict and the challenge to psychology. *British journal of medical psychology* (London), 21:215-21, 1948, Part 3.
- Monsour, Karem J.** Management of chronic alcoholism in the army. *Bulletin, U. S. Army medical department*, 8:882-87, November 1948.
- Moore, Matthew T., M.D.** The treatment of epilepsy. *Pennsylvania medical journal*, 52:31-34, October 1948.
- Morgan, Louise.** Britain's nursery schools. *Childhood education*, 25:32-34, September 1948.
- Mowrer, O. H.** Learning theory and the neurotic paradox. *American journal of orthopsychiatry*, 18:571-610, October 1948.
- Munro, Marian.** The rôle of the social worker in relation to therapy in a state mental hospital. *Journal of psychiatric social work*, 18:10-17, Summer 1948.
- Murray, Warren G., M.D.** "Our objectives." *American journal of mental deficiency*, 53:6-13, July 1948.
- Myerson, Abraham, M.D.** Scrutiny, social anxiety, and inner turmoil in relationship to schizophrenia. *American journal of psychiatry*, 105: 401-9, December 1948.
- Nash, Ethel.** Mental hygiene and sex education. *Understanding the child*, 17:111-12, October 1948.
- Neider, Elizabeth L.** A nursing course as an aid in the rehabilitation of women mental patients. *Mental hygiene*, 32:625-30, October 1948.
- Neuer, Hans, M.D.** The constitutional emotional and cultural factors producing mental deficiency. *Illinois medical journal*, 94:255-60, October 1948.
- Neustaedter, Eleanor.** The field supervisor as educator. *Journal of social casework*, 29:375-82, December 1948.
- New York state youth commission.** "Families first." *Understanding the child*, 17:102-4, October 1948.
- Newman, Israel, M.D.** Character types. *American journal of psychotherapy*, 2:372-82, July 1948.
- Nisonger, Herschel W.** Ohio's program for mentally deficient children. *American journal of mental deficiency*, 53:103-8, July 1948.
- Nordfleet, Grizzelle.** Emotions and our mental hygiene progress. *Physical therapy review*, 28:133-35, May-June 1948.
- Norman, Elizabeth.** The play of a psychotic child: illustrated with drawings by the child. *British journal of medical psychology* (London), 21: 155-70, 1948, Part 3.
- Northern Ireland's Mental health act.** Mental health. *National association for mental health* (London), 8:17-18, August 1948.
- O'Connor, William A.** Some notes on suicide. *British journal of medical psychology* (London), 21:222-28, 1948, Part 3.
- Odlum, Doris M.** Mental health comes alive: impressions of the International congress on mental health, London, August 11-21, 1948. *Journal of the American medical women's association*, 3:407-10, October 1948.
- Odlum, Doris M.** The rebellious child. *Nutrition and child welfare* (London), 3:3-8, October 1948.
- O'Hollaren, Paul, M.D. and Lemere, Frederick, M.D.** Conditioned-reflex treatment of chronic alcoholism: results obtained in 2,323 net cases from 3,125 admissions over a period of ten and a half years. *New England journal of medicine*, 239:331-33, August 26, 1948.
- O'Keefe, Daniel.** Mental hygiene facilities for the juvenile delinquent. *Federal probation*, 12:31-35, June 1948.

- Opler, Morris E.** Some implications of culture theory for anthropology and psychology. *American journal of orthopsychiatry*, 18:611-21, October 1948.
- Orton, R., M.D. and Martin, D. R.** Psychiatric screening of medical students. *Lancet* (London), 255:321-23, August 28, 1948.
- Osborne, Ernest G.** When their feelings are hurt. *National parent-teacher*, 43:14-16, September 1948.
- Otto, John L., M.D.** Vocational rehabilitation of epileptics in Texas. *American journal of psychiatry*, 105: 417-19, December 1948.
- Overstreet, Bonaro W.** The high art of belonging. I. Childhood is the starting point. *National parent-teacher*, 43:22-24, September 1948.
- Palmer, Walter L., M.D.** Posthospitalized patient with cancer: medical and psychiatric aspects. *Journal of the American medical association*, 137:1583-85, August 28, 1948.
- Parker, Rose E.** Undergraduate preparation for teachers of exceptional children. *Sight-saving review*, 18: 63-69, Summer 1948.
- Partridge, Deborah C.** Helping teachers understand the nature of learning. *Understanding the child*, 17:113-14, October 1948.
- Paterson, Arthur S., M.D. and Milligan, W. L., M.D.** The technique and application of electronarcosis. *Proceedings of the Royal society of medicine, Section of psychiatry* (London), 41:575-86, September 1948.
- Patterson, R. M.** Classroom procedures in a prolonged pre-academic program for mentally retarded boys. *Journal of exceptional children*, 15:15-20, 27, October 1948.
- Pease, Sybil H.** Mental hygiene aspects of nursing. *Ohio nurses review*, 23:206-8, October 1948.
- Penrose, Lionel S.** The supposed threat of declining intelligence. *American journal of mental deficiency*, 53:114-18, July 1948.
- Pescor, Michael J., M.D.** Abnormal personality types among offenders. *Federal probation*, 12:3-8, June 1948.
- Peterman, Myrie G., M.D.** Epilepsy in childhood: newer methods of diagnosis and treatment. *Journal of the American medical association*, 138: 1012-19, December 4, 1948.
- Petry, Lucile.** International congress on mental health. *Public health nursing*, 40:557-58, November 1948.
- Phelps, Winthrop M., M.D. and Turner, T. A.** Left hand, right hand: the experience of doctors with cerebral palsied children sheds light on the problems of handedness. *Hygeia*, 26: 808-9, 822, November 1948.
- Pichot, Pierre.** French pioneers in the field of mental deficiency. *American journal of mental deficiency*, 53:128-37, July 1948.
- Porter, E. L. H.** Meeting requirements of population statistics. *American journal of mental deficiency*, 53:165-81, October 1948.
- Powdermaker, Florence, M.D. and Frank, J. D., M.D.** Group psychotherapy with neurotics. *American journal of psychiatry*, 105:449-55, December 1948.
- Preble, Dorothy and Davidoff, Eugene, M.D.** Recreational therapy for epileptic patients. *Mental hygiene news, New York state department of mental hygiene*, 19:3, October 1948; 4, November 1948.
- Rademacker, A., M.D.** The colony of Gheel: effects of war and present problems. *Mental health, National association for mental health* (London), 8:13-16, August 1948.
- Rado, Sandor, M.D.** Graduate residency training in psychoanalytic medicine. *American journal of psychiatry*, 105:111-15, August 1948.
- Rank, Beata, Putnam, M. C., M.D. and Rochlin, Gregory, M.D.** The significance of the "emotional climate" in early feeding difficulties. *Psychosomatic medicine*, 10:279-83, September-October 1948.
- Rauch, David.** The caseworker in family life education. *Journal of social casework*, 29:362-65, November 1948.
- Rautman, Emily and Rautman, Arthur.** Talking to a child. *Mental hygiene*, 32:631-37, October 1948.
- Rawley, Callman.** The adjustment of Jewish displaced persons. *Journal of social casework*, 29:316-21, October 1948.
- Raymond, Charles S., M.D.** The development of the program for the mentally defective in Massachusetts for the past one hundred years (1848-1948). *American journal of mental deficiency*, 53:80-91, July 1948.
- Reed, Ellery F.** How effective are group-work agencies in preventing delinquency? *Social service review*, 22:340-48, September 1948.
- Reed, Roy E., M.D.** A case of involutional psychosis, paranoid type. *Delaware state medical journal*, 20: 168-70, August 1948.
- Reik, Theodor.** The original of the "Sleeping beauty" discovered. *Bulletin of the Menninger clinic*, 12:166-67, September 1948.
- Reitman, F., M.D.** Evaluation of leu-

- cotomy results. American journal of psychiatry, 105:86-89, August 1948.
- Reitzel, Elbert C., M.D. and others.** Neuropsychiatric screening of a million men. U. S. naval medical bulletin, 48:555-65, July-August 1948.
- Rennie, Thomas A. C., M.D.** Stop dodging your duty toward the mentally ill. Modern hospital, 71:92, 94, October 1948.
- Rennie, Thomas A. C., M.D., Menninger, W. C., M.D. and Eisenhower, D. D.** Remarks on the International congress on mental health. Mental hygiene, 32:638-48, October 1948.
- Ripley, Herbert S., M.D., Wolf, Stewart, M.D. and Wolff, H. G., M.D.** Treatment in a psychosomatic clinic: preliminary report. Journal of the American medical association, 138:949-51, November 27, 1948.
- Robbins, Lewis L., M.D.** Psychological factors in essential hypertension. Bulletin, Menninger clinic, 12:195-202, November 1948.
- Rockmore, Myron J. and Kenworthy, M. E., M.D.** The psychiatric social worker functioning at intake in a community clinic for adults. American journal of psychiatry, 105:196-203, September 1948.
- Roland, Paul E.** An exploratory training technique for the re-education of catatonics. American journal of psychiatry, 105:353-56, November 1948.
- Rome, Howard P., M.D.** Psychiatry in clinical medicine. Diseases of the nervous system, 9:305-7, October 1948.
- Rosenbaum, Milton, M.D. and Crede, R. H., M.D.** Chronic rheumatic fever with rheumatic heart disease. Psychosomatic conference — Cincinnati general hospital. Diseases of the nervous system, 9:314-21, October 1948.
- Ross, Ira S., M.D.** The recognition and management of epileptic syndromes. Journal of the Medical society of New Jersey, 45:499-505, October 1948.
- Ross, William D., M.D.** Group psychotherapy with psychotic patients and their relatives. American journal of psychiatry, 105:383-86, November 1948.
- Rubé, P., M.D.** Healing processes in schizophrenia. Journal of nervous and mental disease, 108:304-46, October 1948.
- Rubin, Sidney, M.D.** The psychiatric history in the teaching of psychosomatic medicine. Bulletin, Menninger clinic, 12:182-86, November 1948.
- Rutherford, Berneice R.** Speech as related to physical therapy. Physical therapy review, 28:130-32, May-June 1948.
- Sarason, Seymour B.** The TAT (Thematic Apperception Test) and subjective interpretation. Journal of consulting psychology, 12:285-99, September-October 1948.
- Sargant, William, M.B.** Physical methods of treatment in psychiatry and their implications to general medicine. North Carolina medical journal, 9:367-71, August 1948.
- Scheidlinger, Saul.** Group therapy—its place in psychotherapy. Journal of social casework, 29:299-304, October 1948.
- Schmideberg, Melitta, M.D.** Psychiatrists say: a child must love and hate. Parents' magazine, 23:32-33, 129-33, October 1948.
- Schmidl, Fritz.** Use of the Rorschach personality test. Focus, National probation and parole association, 27:133-37, September 1948.
- "School is fun."** Understanding the child, 17:105-6, October 1948.
- Schumacher, Henry C., M.D.** The integration of mental hygiene concepts and practices in a public health program. Canadian journal of public health (Toronto), 39:351-57, September 1948.
- Schuster, Sir George.** Human relations in industry. British medical journal (London), p. 505-10, September 11, 1948.
- Schwartz, Louis A., M.D.** Psychosomatic aspects of peptic ulcer. Journal of the Michigan state medical society, 47:995-1000, September 1948.
- Schwartz, Louis A., M.D.** The public health nurse in the mental hygiene field. Public health nursing, 40:464-69, September 1948.
- Schwartz, Louis A., M.D.** Today's challenge for personal adjustment. Harper hospital bulletin, p. 136-39, September-October 1948.
- Scott, William C. M., M.D.** Psychiatric problems amongst evacuated children: British journal of medical psychology (London), 21:171-74, 1948, Part 3.
- Seeman, Julius.** A study of preliminary interview methods in vocational counseling. Journal of consulting psychology, 12:321-30, September-October 1948.
- Seliger, Robert V., M.D.** A preliminary report on extramural treatment of severe delirium tremens with recovery in ten hours. American journal of psychiatry, 105:129-30, August 1948.

- Seliger, Robert V., M.D. The psychiatrist looks at contemporary alcoholism. *American journal of psychotherapy*, 2:383-97, July 1948.
- Sellin, Thorsten. The treatment of offenders in Sweden. *Federal probation*, 12:14-18, June 1948.
- Sena, Carmen T., M.D. Psychiatric residency. *Delaware state medical journal*, 20:172-73, August 1948.
- Senn, Milton J. E., M.D. Focal points in child development. *Wisconsin medical journal*, 47:861-64, September 1948.
- Shaffer, Thomas E., M.D. Medicine in a state program for mental deficiency. *American journal of mental deficiency*, 53:294-301, October 1948.
- Shalit, Pearl. The psychiatric nurse in a community mental health program. *American journal of psychiatry*, 105:377-80, November 1948.
- Siegal, Lewis J., M.D. Psychodynamic patterns and their implications in the neuropsychic entities. *Diseases of the nervous system*, 9:308-13, October 1948.
- Silverberg, William V., M.D. The concept of transference. *Psychoanalytic quarterly*, 17:303-21, July 1948.
- Sloan, William. Prediction of extramural adjustment of mental defectives by use of the Rorschach test. *Journal of consulting psychology*, 12:303-9, September-October 1948.
- Smith, Harry L., M.D. and Hightower, N. C., Jr., M.D. Incidence of functional disease (neurosis) among patients of various occupations. *Occupational medicine*, 5:182-85, February 1948.
- Smith, Leo F. and Lipsett, Laurence. Psychological services for an industrial community. *Personnel journal*, 27:130-34, September 1948.
- Snaith, Linton, M.D. and Ridley, Brenda, M.B. Gynaecological psychiatry: a preliminary report on an experimental clinic. *British medical journal* (London), p. 418-21, August 28, 1948.
- Some classroom problems: solved and unsolved. *Understanding the child*, 17:115-19, October 1948.
- Spaulding, V. V. A study of nurse and police applicants. *Delaware state medical journal*, 20:177-78, August 1948.
- Spindler, G. D. American character as revealed by the military: descriptions and origins. *Psychiatry*, 11:275-81, August 1948.
- Stekel, Wilhelm, M.D. Autobiography (VI). *American journal of psychotherapy*, 2:417-37, July 1948.
- Stevenson, George S., M.D. Potentials for mental hygiene activities under public health authority. *American journal of orthopsychiatry*, 18:685-90, October 1948.
- Stevenson, George S., M.D. When a community plans for mental health. *Child, U. S. Children's bureau*, 13:72-74, November 1948.
- Stevenson, George S., M.D. World implications of mental deficiency. *American journal of mental deficiency*, 53:109-13, July 1948.
- Stoller, Alan. Social health and psychiatric service. *Medical journal of Australia* (Sydney), 2-35th yr.: 29-37, July 10, 1948.
- Stone, Marguerite M. Parental attitudes to retardation. *American journal of mental deficiency*, 53:363-72, October 1948.
- Stransky, Erwin, M.D. Postwar psychiatry and neurology in Vienna. *American journal of psychiatry*, 105:426-28, December 1948.
- Strecker, Edward A., M.D. and Chambers, F. T., Jr. How to help a problem drinker. *Hygeia*, 26:866-67, 897-98, December 1948.
- Sullivan, Harry S., M.D. Two international conferences of psychiatrists and social scientists. *Psychiatry*, 11:223-29, August 1948.
- Sunderland, Edson R. Proposals for improving Michigan's practices of committing persons to state hospitals. *Mental hygiene bulletin*, Michigan society for mental hygiene, 6:2-4, August 1948.
- Sylvester, Lorna. Casework process in a child guidance clinic in a psychiatric setting. *Journal of psychiatric social work*, 18:17-24, Summer 1948.
- Tarjan, George, M.D. Current thinking regarding psychopaths. *American journal of mental deficiency*, 53:302-11, October 1948.
- Tarnower, Samuel M., M.D. Psychiatry in a general hospital of a small city. *New England journal of medicine*, 239:466-68, September 23, 1948.
- Tarumianz, Mesrop A., M.D. Governor Bacon health center. *Delaware state medical journal*, 20:155-56, August 1948.
- Thomas, Henry M., Jr., M.D. What is psychotherapy to the internist? *Journal of the American medical association*, 138:878-80, November 20, 1948.
- Tilkin, Leonard, M.D. Use of sodium pentothal in psychiatry. *Diseases of the nervous system*, 9:340-42, November 1948.
- Tolstoi, Edward, M.D. The objectives of modern diabetic care. *Psychoso-*

- matic medicine, 10:291-94, September-October 1948.
- Tompkins, J. Butler, M.D.** A summary of thirty-six cases of lobotomy. *American journal of psychiatry*, 105: 443-44, December 1948.
- Trost, Theodore L., Jr.** Youth needs to share responsibility. *Child study*, 25:103-4, 114, Fall 1948.
- Tudor, Richard B., M.D.** Treatment of epilepsy. *Journal-Lancet*, 68:391-94, October 1948.
- UNESCO conference on world tensions: an international multidisciplinary group.** *Psychiatry*, 11:231-33, August 1948.
- Valenstein, Arthur F., M.D.** Problems in the treatment of the neurotic veteran. *Journal of nervous and mental disease*, 108:211-16, September 1948.
- Van Bark, Bella S., M.D.** "The sudden guest." A critical analysis. *American journal of psychoanalysis*, 8:59-62, 1948, No. 1.
- Veit, Henry, M.D.** Early schizophrenia complicated by rheumatic fever. *Wisconsin medical journal*, 47:865-67, September 1948.
- Vevie, Mendus R.** A report on the organization of a school with a separate campus prepared to give training to mentally deficient boys and girls in anticipation of their return to normal community living. *American journal of mental deficiency*, 53:199-206, October 1948.
- Vogel, Victor H., M.D.** Treatment of the narcotic addict by the U. S. Public health service. *Federal probation*, 12:45-50, June 1948.
- von Hentig, Hans.** The suspect: a study in the psychopathology of social standards. *Journal of criminal law and criminology*, 39:19-33, May-June 1948.
- Walker, Edmund F., M.D.** The syndrome of delirium. *Diseases of the nervous system*, 9:336-39, November 1948.
- Walker, Gale H., M.D.** Some psychosexual considerations of institutionalized mental defectives. *American journal of mental deficiency*, 53:312-17, October 1948.
- Wallen, Richard.** Food aversions in behavior disorders. *Journal of consulting psychology*, 12:310-12, September-October 1948.
- Wardley, Annetta.** Psychotherapy and its implications in regard to cerebral palsy. *Spastic review*, 9:5-6, 8, October 1948.
- Washburn, Ruth W.** Parents and teachers in partnership. *Parents' magazine*, 23:36-37, 125-28, October 1948.
- Watson, George A., M.D.** Psychic disturbances in children with chronic illness. *North Carolina medical journal*, 9:547-49, November 1948.
- Watters, Theodore A., M.D.** The neurotic struggle in senescence. *Geriatrics*, 3:301-5, September-October 1948.
- Wearne, Raymond G., M.D.** A résumé of medical and psychiatric developments in mental deficiency during the past ten years. *American journal of mental deficiency*, 53:47-56, July 1948.
- Weitzel, Kathryn S.** The integration of home economics in the training of casework staff. *Journal of social casework*, 29:304-10, October 1948.
- Whitaker, Carl A., M.D.** Compensation for psychiatric disabilities in industry. *Occupational medicine*, 5:391-95, April 1948.
- White, Benjamin V., M.D.** Psychoneuroses: clinical evaluation by the internist. *Connecticut state medical journal*, 12:522-25, June 1948.
- Whitney, E. A., M.D.** A statistical study of children admitted and discharged from Elwyn. *American journal of mental deficiency*, 53:182-86, October 1948.
- Wikler, Abraham, M.D.** Recent progress in research on the neurophysiologic basis of morphine addiction. *American journal of psychiatry*, 105:329-38, November 1948.
- Wildenskov, H. O., M.D.** The care of mental defectives in Denmark and the Keller institutions for mental defectives. *American journal of mental deficiency*, 53:138-44, July 1948.
- Williams, John F., M.D.** Psychosomatic medicine. *Virginia medical monthly*, 75:452-55, September 1948.
- Wilson, David C., M.D.** The psychosomatic effects of chronic invalidism. *Virginia medical monthly*, 75:553-58, November 1948.
- Wilson, George W., M.D.** A further contribution to the study of olfactory repression with particular reference to transvestitism. *Psychoanalytic quarterly*, 17:322-39, July 1948.
- Winnicott, Donald W.** Children's hostels in war and peace. *British journal of medical psychology (London)*, 21:175-80, 1948, Part 3.
- Wise, Carroll A.** Some practical problems in counseling in the parish. *Journal of clinical pastoral work*, 1: 1-5, Summer 1948.
- Wittenberg, Rudolph.** Before the teens—what to expect of our children. *Child study*, 25:101-2, 124, Fall 1948.

- Wittman, Phyllis and Sheldon, William, M.D.** A proposed classification of psychotic behavior reactions. *American journal of psychiatry*, 105:124-28, August 1948.
- Witty, Paul A.** The needs of bright and gifted children. *NEA journal*, National education association, 37: 358-59, September 1948.
- Witty, Paul A.** The rôle of attitudes in children's failures and successes. *NEA journal*, National education association, 37:422-23, October 1948.
- Wolf, William, M.D.** The problem of the psychosomatic patient. *American journal of psychotherapy*, 2:438-40, July 1948.
- Wolford, Opal P.** How early background affects dating behavior. *Journal of home economics*, 40:505-6, November 1948.
- Wood, Kenneth S.** The parent's rôle in the clinical program. *Journal of speech and hearing disorders*, 13:209-10, September 1948.
- Woodcock, Louise P.** Standards for the nursery age. *Child study*, 25: 99-100, 122-23, Fall 1948.
- Woods, Ruth.** Glutamic acid and intellectual performance. *Borden's review of nutrition research*, 9:1-11, September 1948.
- Yakovlev, Paul I., M.D., Weinberger, Maximilian, M.D. and Chipman, C. E.** Heller's syndrome as a pattern of schizophrenia behavior disturbance in early childhood. *American journal of mental deficiency*, 53:318-37, October 1948.
- Yepsen, Lloyd N.** Problems and a program for action. *American journal of mental deficiency*, 53:15-23, July 1948.
- Young, Reginald J., M.D.** The value of the Rorschach test in differential diagnosis. *American journal of psychiatry*, 105:381-82, November 1948.
- Zietz, Dorothy.** Privileged communication and the teacher. *School and society*, 68:298-99, October 30, 1948.
- Zimmerman, Claire.** What I learned in an art education class. *Understanding the child*, 17:120-21, October 1948.
- Ziskind, Louis.** The caseworker's relation to shock therapy. *Journal of social casework*, 29:389-94, December 1948.
- Zuckerman, Stanley B.** A research suggestion in large-scale Rorschach. *Journal of consulting psychology*, 12:300-2, September-October 1948.

STATE MENTAL-HYGIENE ORGANIZATIONS

- Alabama Society for Mental Hygiene.** Mrs. R. I. Schwartz, 17 Winthrop Ave., Birmingham 9, Ala.
- Arizona Society for Mental Hygiene.** Rev. A. K. Krohn, President, 318 West Granada, Phoenix, Ariz.
- Northern California Society for Mental Hygiene.** G. Eleanor Kimble, Ph.D., Executive Secretary, 1095 Market Street, San Francisco 3, Calif.
- Southern California Society for Mental Hygiene.** Mrs. Helene M. Lipscomb, Executive Director, 600 South Hobart Blvd., Los Angeles 5, Calif.
- Connecticut Society for Mental Hygiene.** Miss Frances Hartshorne, Executive Secretary, 152 Temple St., New Haven 10, Conn.
- Delaware Society for Mental Hygiene.** H. Edmund Bullis, Executive Director, 1308 Delaware Ave., Wilmington 19, Del.
- Florida: Mental Health Society of Southeastern Florida.** Chester M. Wright, President, 700 S.W. 12th Ave., Miami 36, Fla.
- Idaho and Eastern Washington: Interstate Mental Hygiene Association.** L. J. Elias, President, % Department of Rural Sociology, Washington State College, Pullman, Wash.
- Illinois Society for Mental Hygiene.** Dr. Rudolph G. Novick, Medical Director, 123 W. Madison St., Chicago 2, Ill.
- Indiana Mental Hygiene Society.** Mrs. Alice Sanders, Secretary, 901 Lemcke Bldg., Indianapolis, Ind.
- Iowa State Society for Mental Hygiene.** Dr. Norman D. Render, Executive Director, % State Hospital, Clarinda, Iowa.
- Kansas Mental Hygiene Society.** Dr. Lewis L. Robbins, % Menninger Clinic, Topeka, Kans.
- Kentucky Mental Hygiene Association.** Mrs. Ella Layne Brown, Executive Secretary, 220 Capitol Ave., Frankfort, Ky.
- Louisiana Society for Mental Health.** Loyd Rowland, Executive Secretary, 816 Hibernia Bank Building, New Orleans 12, La.
- Maine Teachers Mental Hygiene Association.** University of Maine, Orono, Me.
- Maryland Mental Hygiene Society.** Dr. Ralph P. Truitt, Executive Secretary, 601 West Lombard St., Baltimore 1, Md.
- Massachusetts Society for Mental Hygiene.** William H. Savin, Executive Secretary, 3 Joy Street, Boston 8, Mass.
- Michigan Society for Mental Hygiene.** Harold G. Webster, Executive Secretary, 153 E. Elizabeth St., Room 645, Detroit 1, Mich.
- Minnesota Mental Hygiene Society.** Mr. Edward I. Morse, Executive Secretary, 309 E. Franklin Ave., Minneapolis 4, Minn.
- Missouri Association for Mental Hygiene.** Mrs. Elizabeth Lingenfelter, Secretary, 1020 McGee St., Kansas City 6, Mo.
- Nevada State Mental Hygiene Society.** Dr. Walter Bromberg, 140 North Virginia St., Reno, Nev.
- New York State Committee on Mental Hygiene of the State Charities Aid Association.** Mrs. Mildred Buchwalder Beck, Acting Executive Secretary, 105 East 22nd St., New York 10, N. Y.
- North Carolina Mental Hygiene Society.** Harry K. Dorsett, Secretary, Meredith College, Raleigh, N. C.
- Ohio Mental Hygiene Association.** Mrs. Marion S. Wells, Acting Executive Secretary, 1014-15 Huntington Bank Bldg., Columbus 15, Ohio.
- Oklahoma Committee for Mental Hygiene.** W. James Logan, Executive Secretary, 620 N.W. 21, Oklahoma City 3, Okla.
- Oregon: Mental Health Association of Oregon.** Miss June J. Joslyn, Executive Secretary, 229 Park Bldg., Portland 5, Ore.
- Pennsylvania: Mental Hygiene Division, Public Charities Association of Pennsylvania.** Ross W. Sanderson, Jr., Secretary, 311 South Juniper St., Philadelphia, Pa.
- Rhode Island Society for Mental Hygiene.** Dr. Gertrude Muller, Medical Director, 100 North Main St., Providence, R. I.
- South Carolina Mental and Social Hygiene Society.** Maisie Bookhardt, Secretary, State Health Department, Clinton, S. C.

South Dakota Mental Health Association, 300 First National Bank Bldg., Sioux Falls, S. D.

Texas Society for Mental Hygiene. Mrs. Elizabeth F. Gardner, Executive Secretary, 1617 Watchhill Road, Austin 21, Tex.

Utah Society for Mental Hygiene. Charles L. McKell, Executive Secretary, Box 270, Provo, Utah.

Vermont Society for Mental Hygiene, Miss Harriet Parker, Secretary, 311 North Avenue, Burlington, Vt.

Virginia Mental Hygiene Society. Mr. F. W. Gwaltney, Executive Secretary, 309 North 12th St., Richmond 19, Va.

Washington Society for Mental Hygiene. George F. Ault, Executive Secretary, 408 Seaboard Bldg., Seattle 1, Wash.

Wisconsin Society for Mental Health. Dr. Esther H. DeWeerd, Executive Director, 405 East Grand Ave., Beloit, Wis.

Hawaii Territorial Society for Mental Hygiene. Mrs. A. W. Hackfield, Executive Secretary, P. O. Box 39, Honolulu 10, T. H.

